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COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

BUDGET RECONCILIATION RECOMMENDATIONS OF THE COMMITTEE ON WAYS AND MEANS

(Title X of the Omnibus Budget Reconciliation Act of 1986)

ORIGINAL

JULY 30, 1986

Prepared for the use of the Committee on Ways and Means by its staff

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COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

July 28, 1986

The Honorable William H. Gray, III
Chairman
Committee on the Budget
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Pursuant to the reconciliation instruction contained in S. Con. Res. 120, I am transmitting the recommendations of the Committee on Ways and Means approved in our mark-up on July 23. As you requested, enclosed are the legislative language, explanatory material and report language, CBO cost estimates of the legislation, and additional views.

Total deficit reduction achieved by the Committee from Fiscal Year 1987 to 1989 is $12.0 billion. This is $.4 billion more than the budget resolution assumed. Concerns have been raised about the fact that the 1987 deficit target was not met. Given Gramm-Rudman and the potential sequester order which might result, these concerns are legitimate. Consequently, I will make every effort to ensure that the target for Fiscal Year 1987 will be achieved.

By a unanimous vote of the Committee, I have been directed to seek a closed rule on the title of the reconciliation bill which contains the recommendations of the Committee on Ways and Means.

If you have any questions, please contact Committee staff.

Sincerely,

Dan Rostenkowski

Dan Rostenkowski
Chairman

DR/wof

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Report To Accompany Recommendations From the Committee on Ways and Means

I. SUMMARY

Subtitle A -- SOCIAL SECURITY PROVISIONS

(1) Eliminate the COLA Trigger. -- The bill would eliminate the requirement that the increase in the CPI must reach three percent before a COLA is provided to social security beneficiaries. The provision would, therefore, ensure that a social security benefit increase will be paid in the January, 1987, benefit checks. This provision would have the effect of eliminating the trigger for several other automatic adjustments that increase only if a social security COLA is provided (e.g., the FICA wage base, the medicare part B beneficiary premium, and SSI, railroad retirement, and Veterans' pension COLAs).

(2) State and Local Deposits. -- The bill would relieve the States of the responsibility for collecting the social security contributions of its political subdivisions, and would place all State and local government employers under a depositing schedule that conforms with the frequency required of private employers. This provision would be effective January 1, 1987.

Subtitle B -- PUBLIC ASSISTANCE AND UNEMPLOYMENT COMPENSATION PROVISIONS

(1) Aid to Families With Dependent Children (AFDC) for Unemployed Two-Parent Families (AFDC-UP). -- The bill requires all State AFDC programs to offer coverage to financially eligible two-parent families in which the principal earner is "unemployed," defined as working fewer than 100 hours per month. This is currently a State option. Twenty-four States and two territories do not now provide AFDC to such families.

(2) Annual Calculation of the Federal Percentage of AFDC Expenditures. -- P.L. 99-272 requires an annual rather than biennial calculation of the Federal AFDC percentage beginning in FY 1987. This results in a loss of AFDC funds to 13 States. The bill restores these funds for FY 1987 only.

(3) Income and Eligibility Verification System. -- Section 1137 of the Social Security Act requires States to establish an income and eligibility verification system for certain public assistance programs. Under the system, States must request and make use of quarterly wage data and unearned income data supplied by the Internal Revenue Service (IRS). The bill clarifies that Congress intends that the system be targeted to those uses which are likely to be most productive. States would be permitted to prioritize and target the follow-up and review of case records based on the information supplied.

(4) Two-Year Extension of Temporary Federal Unemployment Tax (FUTA). -- Generally, employers pay FUTA tax of .8% on the first $7,000 in wages paid to an employee. Under current law, the tax will automatically decrease to .6% on January 1, 1988. The bill would extend the tax at the .8% rate for two years.

Subtitle C -- MEDICARE AND HEALTH PROGRAMS

(1) Limit Increase in Part A Deductible. -- For calendar year 1987, the hospital deductible would be $500. In future years, current law would prevail.

(2) Hospital Rate of Increase. -- Hospitals would be provided a 1.3% increase in the prospective payment rates for FY 1987 and an increase of the hospital market basket minus 2.0% for FY 1988.

Hospitals exempt from the prospective payment system would be provided a 1.3% increase in the cost limits for FY 1987, and an increase hospital market basket minus 2.0% for FY 1988.

The Secretary of Health and Human Services (HHS) would be required to recalibrate the Diagnostic Related Groups (DRG's) annually.

(3) Capital Reimbursement under Medicare. -- The rate of increase in aggregate capital expenditures for inpatient hospital services would be capped. The rate of increase for FY 1987 would be limited to aggregate expenditures in FY 1986 plus 10%. The rate of increase for FY 1988 would be limited to aggregate expenditures in FY 1986 plus 20%, and the increase in FY 1989 would be limited to aggregate expenditures in FY 1986 plus 30%. This provision would only apply to PPS hospitals.

(4) Include Puerto Rico into the Prospective Payment System (PPS) with Appropriate Adjustments. -- The Secretary would be required to include Puerto Rico in the prospective payment system. The rates would be established at a 75% Puerto Rico-specific standardized rate and a 25% national standardized rate.

The Secretary would be required to base the Puerto Rico-specific payments on urban and rural standardized rates. Additional adjustments would be made for indirect teaching costs and for eligible disproportionate share hospitals.

The Secretary would be prohibited from restandardizing the national DRG rate to reflect Puerto Rico's inclusion into the prospective payment system.

(5) Quality Protection. -- The Secretary would be required to develop a plan to refine the prospective payment system for hospitals to adjust for severity of illness. Hospitals would be required to provide a statement of patient rights to beneficiaries. Beneficiaries would have a right to appeal hospital discharge notices and would not be liable for continued inpatient stay until after the appeal is decided. Hospitals, health maintenance organizations (HMO's), and competitive medical plans (CMP's) would be prohibited from paying physicians to reduce or limit services to beneficiaries. The prohibition would be effective for hospitals six months after enactment and would be effective for HMO's and CMP's on January 1, 1988. HHS would be required to submit a report to Congress by April 1, 1987, concerning appropriate exceptions to the prohibition for HMO's and CMP's. HHS would be required to study the adequacy of medicare's quality assurance standards for hospitals and the need for payment for administratively necessary days.

Hospitals would be required to provide discharge planning. The favorable presumption of the waiver of liability for medical necessity and custodial care denials for hospice, home health and skilled nursing facility services would be extended through September 30, 1989. A waiver of liability would be established for homebound and intermittent care denials for home health services, and a favorable presumption for these denials would be effective through September 30, 1989. HHS would be required to develop a uniform needs assessment instrument and would be required to develop an expedited review process for post-hospital services. Providers would be allowed to bring appeals on behalf of beneficiaries; appeals of technical denials would be allowed. HHS would be required to include information concerning quality in its annual report on prospective payment and would be required to conduct a demonstration project concerning prior authorization for home health and skilled nursing facility services.

HHS would be required to ensure that Peer Review Organizations (PRO's) receive data needed to conduct reviews on a timely basis. PRO review of early readmission cases would be expanded. Each PRO would be required to provide for a reasonable allocation of its quality review effort among all medicare providers. PRO's would be required to appoint a consumer representative to their executive boards and would be required to investigate written complaints about quality of care. Confidential information obtained by PRO's could be shared with national accreditation bodies and with long-term care ombudsmen and state protection and advocacy officials. PRO funding would be increased to cover the cost of the new PRO activities.

HHS would be required to contract with the Institute of Medicine to conduct a study to assist in the development of a long-term strategy for quality assurance.

(6) Hospital Insurance Trust Fund Off-Budget in 1987. -- The effective date of the provision of the Social Security Act that removes the receipts and disbursements of the Federal Hospital Insurance Trust Fund from the unified budget would be accelerated from FY 1993 to FY 1987.

(7) Eliminate Periodic Interim Payments (PIP) with Prompt Pay for Providers. -- The periodic interim payment would be eliminated effective July 1, 1987, for all hospitals for inpatient services except for services provided in "disproportionate share" hospitals, sole community hospitals and PPS-exempt hospitals and units. Furthermore, other cost-based providers would continue to receive periodic interim payments. The Secretary would be required to make advance payments to hospitals, if the hospital can demonstrate that elimination of the PIP option is causing significant financial difficulty.

The Secretary would be required to pay Part A "clean" claims within 22 calendar days of receipt beginning on July 1, 1987. "Clean" claims submitted by participating physicians and suppliers would be required to be paid within 11 days beginning in FY 1988, and within 22 days for nonparticipating physicians and suppliers beginning in FY 1988.

If the claim is not paid in the required time period, a notice must be sent to the beneficiary, physician, supplier or provider submitting the claim to inform them of expected delays. If the claim is not paid or a notice mailed, interest would begin to accrue on the day following the day on which payment was due.

(8) Health Maintenance Organization Amendments. -- The HMO amendments include provisions regarding, (a) composition of enrollment, (b) authority to impose civil monetary penalties, (c) a study on the adjusted average per capita cost and the adjusted community rate, (d) prompt payment of claims, (e) allowing beneficiaries to disenroll from an HMO at a local Social Security Office, (f) allowing the Health Care Finance Administration (HCFA) access to financial records of subcontractors of HMO's and CMP's and (g) requiring provision of an explanation of patient rights.

(9) Eliminate Health Maintenance Organization Two for One Rule. -- The requirement that HMO's that had or have a medicare cost contract but which sign a section 1876 risk contract must enroll two new medicare risk contract enrollees before they can convert one medicare cost contract member would be deleted.

(10) Extend Part B 25% Premium Policy for One Year. -- The existing temporary provision of law whereby the portion of part B program costs financed by premium income equals 25% would be extended for one additional year, through calendar year 1989

(11) Extend and Modify Limits on Physician Fee Increases. -- On January 1, 1987, all physicians will receive an increase equal to the Medical Economic Index (MEI) (now estimated to be 3.2%) in prevailing charges above levels in effect during 1986. In future years, all physicians will receive an increase in prevailing charges equal to the MEI. Participating physicians would receive an additional 1% bonus in 1987 and an increase equal to the MEI in 1988 and 1989. The 1% would not be included in the base and would not compound in future years. Nonparticipating physicians could increase their actual charges

by the MEI plus 1% in 1987 and by the MEI in 1988 and 1989. The 1% would be included in the base and would compound in future years. Special rules apply for new nonparticipating physicians. The Secretary would be prohibited from revising the MEI on a retrospective basis.

(12) Programs to Increase Physician Participation. -- A directory of participating physicians would be sent to each beneficiary starting in 1988. Carriers would be required to implement programs to recruit participating physicians and to familiarize beneficiaries with the participating physician program. An incentive pool would be available for distribution to carriers based on their success in recruiting new participating physicians. The medicare provider agreement for hospitals would be amended to require that hospital personnel provide the name of at least one qualified participating physician when referring a beneficiary for follow-up care on an outpatient basis. Physicians would be prohibited from charging for unnecessary services, whether or not assignment is accepted. Physicians providing high-cost elective surgical procedures on an unassigned basis would be required to provide fee information to the beneficiary in advance of performing the procedure.

(13) Prohibit Administration Regulation on Overpriced Procedures and Require Study. -- The Secretary would be prohibited from using "inherent reasonableness" to establish special reasonable charge limitations for services covered under medicare part B. Payment rates would continue to be determined on the basis of actual, customary and prevailing charges. The Secretary would be required to submit a report to Congress, after consultation with the Physician Payment Review Commission, concerning payment reductions for overpriced procedures.

(14) Reduce Rates to End-Stage-Renal-Disease (ESRD) Facilities and Physicians and Strengthen Networks. -- The facility composite payment rate would be reduced by approximately $5.50 per treatment (4.5%) based upon more recent data on facility mix, and home/in-facility dialysis mix. The base rate could be no lower than $117.50 for free-standing ESRD facilities and no lower than $121.50 for hospital based facilities.

The monthly capitated payment rate for physicians treating ESRD patients would be reduced by approximately $14 (8%) to reflect the shorter period of time spent on patients who receive their care at home.

The Secretary would be required to establish 17 or more networks to carry out the functions and responsibilities as presently set forth in law, and the responsibilities of the networks would include: (a) collecting, validating and evaluating patient and facility data; (b) conducting on-site review of the medical care provided to beneficiaries in facilities; and (c) implementing a procedure for evaluating and resolving patient grievances.

(15) Technical Amendments and Miscellaneous Provisions. -- The provision corrects a number of technical errors in the Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272, and related laws including the disproportionate share, indirect teaching adjustment, prospective payment for skilled nursing facilities, assistants at surgery and direct medical education provisions.

In addition, there are eight other non-cost provisions which would:

(a) Extend the Secretary's authority to enter into two competitively bid contracts under parts A and B of medicare to replace poor performing contracts for three years;

(b) Modify the effective date of disenrollment from medicare when a beneficiary files a notice to disenroll;

(c) Legalize the payment of administrative fees to group purchasing organizations for vendors where full disclosure of such payment is made;

(d) Expand the membership of the Physician Payment Assessment Commission to 13;

(e) Provide a one-year extension of the "pass through" for costs for services of certified registered nurse anesthetists;

(f) Connecticut Hospice, Inc. would be waived for two years from the 80/20 inpatient/home care day requirement. Connecticut Hospice would not be allowed to have more than 50% of total days as inpatient days.

(g) The three-year period granted for rural referral centers status would be extended to four years; and

(h) Require that the Secretary of HHS may not recoup from nor reduce payments to Massachusetts hospitals until January 1, 1988.

(16) High Risk Health Insurance Pools. -- Once a State has established a health insurance pool, any employer with 20 or more employees who does business in the State, would be required to participate in the insurance pool or face a 5% excise tax on gross wages (as defined in Internal Revenue Code sec. 3401) paid or incurred during the taxable year. To the extent the insurance pool is not self-supporting from premiums, losses would be made up by equitable assessments on all participating employers in the State.

The health insurance pool would be available to all residents of the State regardless of health status. Policies would be designed to offer coverage typical of large employer plans in the State, but premiums charged, in no event, could be higher than 150% of average premium rates for individual standard risks in the State for comparable coverage. Coverage standards would be established for lifetime limits, caps on out-of-pocket expenses, deductibles, coverage for pre-existing conditions and durable medical equipment. A State or other entity could provide payment of part or all of the premium of an enrollee and could vary the amount of the payment based on the enrollee's income or on some other basis.

State Legislatures would have until January 1, 1988, to establish a health insurance pool or until the first January 1st that occurs after the close of their first regular State legislative session.

(17) Technical Corrections Concerning Private Health Insurance Continuation Coverage. -- There are several technical corrections which would:

(a) Establish a 60-day notification deadline for divorced and legally separated spouses and dependents who no longer qualify as dependents under the plan's definition;

(b) Clarify that a qualified beneficiary may have more than one qualifying event, but the length of coverage could not exceed 36 months;

(c) Clarify that an election by a qualified beneficiary shall be deemed to be an election for all other qualified beneficiaries in the family, but each qualified beneficiary is entitled to make an individual election;

(d) Specify a 30-day period of time (or longer if the plan permits) for which failure to pay the premium would result in termination of coverage;

(e) Clarify that if coverage is modified for all similarly situated beneficiaries, coverage shall be modified for qualified beneficiaries.

(18) Extend the Private Health Insurance Continuation Coverage. -- The Consolidated Budget Reconciliation Act of 1985 (COBRA) provision would be amended so that in the event that an employer files for Chapter 11 reorganization on or after July 1, 1986, all the retirees, regardless of the date of retirement, their spouses and dependents, who would lose their employer-based health insurance would have the option to elect to continue in the employer based health insurance plan until the death of the retiree, reemployment, remarriage resulting in coverage from the spouse's plan, or failure to pay the premium. Upon the death of the retiree, the widow and dependents could elect to remain in the health plan for up to three years as defined in COBRA.

Subtitle D -- **REVENUE PROVISIONS**

(1) Extension of Telephone Excise Tax. -- Under current law, a three-percent excise tax is imposed on amounts paid for local telephone service, toll telephone service, and teletypewriter exchange service. This excise tax is currently scheduled to terminate after December 31, 1987. Under the new provision adopted by the Committee, it would be extended at a three-percent rate for two years, through December 31, 1989.

SUMMARY OF DEFICIT REDUCTION

The net deficit reduction achieved by the provision summarized above, over the three-year period from 1987-1989, is $12.0 billion, as shown in the attached table. The deficit reduction target for the Committee on Ways and Means in the House-passed budget resolution is a net of $11.6 billion. This includes $12.6 billion in deficit reduction and $1.0 billion in allowed spending.

	Deficit Reduction Achieved from FY 87-89 (in millions)
A. Budget Resolution Targets	
Reconciliation Instruction	$12,635
Allowed Spending	(1,000)
Net Deficit Reduction	11,635
B. Committee Recommendations	
Social Security	
Remove COLA Trigger	--
Accelerate State & Local Deposit of Payroll Taxes	1,846
Public Assistance	
AFDC-UP	(370)
FY 1987 Federal AFDC Percentage	(15)
IEVS Targeting	--
FUTA Repayment Tax Extension	2,150
Medicare	
Set Hospital Deductible at $500 in 1987	(810)
Hospital Payment Increases of 1.3% for FY 87 and Market Basket Minus 2.0% for FY 88	2,670
Limit Aggregate Capital Payment Increases to 10% Annually	1,100
Include Puerto Rico into PPS System	(45)
Quality Protections	(362)
Medicare Off-budget in 1987	--
Eliminate Periodic Interim Payments with Prompt Pay for Providers	1,620
HMO Amendments	--
Eliminate HMO 2-for-1 Rule	(120)
Extend Part B 25% Premium Policy for One Year	440
Extend and Modify Limits on Physician Fee Increase	(50)
Programs to Increase Physician Participation	(200)*
Disallow Administration Regulation on Overpriced Procedures and Require Study	--
Reduce Rates to ESRD Facilities and Physicians and Strengthen Networks	297
Technical Amendments and Miscellaneous Provisions	--
High Risk Health Insurance Pools	--
COBRA Health Insurance Amendments	--
Revenues	
Extend Telephone Excise Tax for 2 Years	3,627
TOTAL (Net Deficit Reduction)	11,978

NOTE: Numbers in parentheses indicate the provision will cost, not save money.

* Not included in totals. Dollar amounts determined by appropriation action.

II. EXPLANATION OF PROVISIONS

Subtitle A. -- Social Security Amendments

1. Elimination of 3-Percent Trigger for Cost-of-Living Increases (sec. 10001 of the bill)

Present law.--The Social Security Act provides for a cost-of-living adjustment (COLA) for benefits under the Old-Age, Survivors, and Disability Insurance program, based on the consumer price index (CPI), if the CPI increases by 3.0 percent or more during a specified base period (currently, the third quarter of the prior year through the third quarter of the current year). If the CPI rises by less than 3.0 percent during the base period, a COLA is not provided. In the following year, however, the COLA is based on the accumulated increase in the CPI over 2 years.

Several other automatic increase provisions are linked to the social security COLA, and are triggered only if the social security COLA is provided. These include the increase in: a) the maximum amount of earnings taxable under FICA and SECA; b) the amount of earnings exempt from the retirement test; c) the Supplementary Medical Insurance (SMI) beneficiary premium; d) railroad retirement, Supplemental Security Income (SSI), and Veteran's pension benefits; and e) certain eligibility standards for medicaid, food stamps, housing assistance, and Aid to Families with Dependent Children (AFDC).

Explanation of provision.--The Committee bill would eliminate the 3 percent trigger for the provision of the social security COLA. A COLA would be provided in any year in which there has been a positive rise in the CPI during the specified base period. This would have the effect of assuring that the other automatic increase provisions linked to the Social Security COLA would also rise in any year in which the CPI rises.

This provision also contains a technical amendment to the SMI program to clarify that in implementing the SMI "hold harmless" provision (mandated by the Deficit Reduction Act of 1984) that the proceeds from rounding social security benefit amounts down to the next lower dollar accrue to the OASDI trust funds.

Effective date.--This provision will be effective for the COLA provided in December 1986.

2. Deposits of Social Security Contributions by State and Local Government Employers (sec. 10002 of the bill)

Present law.--Each State may enter into a voluntary agreement with the Secretary of Health and Human Services to provide social security coverage for employees of the State government and any of its political subdivisions. A State which enters into a coverage agreement is liable for collecting and depositing with the Federal government twice a month employer and employee social security contributions on their own behalf and for sub-State entities. Payments of social security contributions are first made by the local subdivisions to the State, which also is responsible for verifying and consolidating the payments. The State then deposits with the Federal Government these payments and the appropriate amounts with respect to its own employees.

Private employers are required to make payroll tax payments under a schedule that links the frequency of deposits to the amount of taxes withheld. Large employers may make deposits as frequently as eight times a month, while small employers may make them as infrequently as once every 3 months. (These rules also apply to deposits of Federal income taxes withheld by State and local governments from their employees.)

Late deposits by State governments are subject to an interest charge at the rate of 6 percent per year. Private sector employers pay an interest rate that is based on the prime interest rate charged by major commercial banks. This rate is adjusted semi-annually.

Explanation of provision.--The Committee bill removes from the States the intermediary role of collecting social security contributions from sub-State entities and place all State and local government employers under a direct depositing requirement with a schedule that conforms with the frequency required of private employers. States are relieved of liability for collecting and verifying the social security contributions owed by its political subdivisions. In addition, the provision subjects State and local governments to the same interest charge and penalties for late deposits as are imposed on private employers.

Effective date.--The provision is effective for payments of contributions due with respect to wages paid after December 31, 1986.

Subtitle B. -- Public Assistance and Unemployment Compensation Provisions

1. AFDC for Unemployed Two-Parent Families (sec. 10101 of the bill)

Present law.-- States have the option to provide AFDC to financially eligible two-parent families in which the principal earner is "unemployed," defined as working fewer than 100 hours per month.

For eligibility, the law requires that the unemployed parent have worked 6 or more quarters in any 13-calendar quarter period ending within 1 year before applying for AFDC-UP.

States without an AFDC-UP programs are: Alabama, Alaska, Arizona, Arkansas, Colorado, Florida, Georgia, Idaho, Indiana, Kentucky, Louisiana, Mississippi, Nevada, New Hampshire, New Mexico, North Carolina, North Dakota, Oklahoma, South Dakota, Tennessee, Texas, Utah, Virginia, and Wyoming. The Virgin Islands and Puerto Rico also do not have AFDC-UP.

Explanation of provision.-- The bill requires all State AFDC programs to offer assistance to financially eligible two-parent families in which the principal earner is "unemployed," defined as working fewer than 100 hours per month.

In addition, the definition of "quarters of work" would be modified. States would be permitted to substitute for 4 of the requisite 6 quarters of work, quarters of full-time attendance in elementary or secondary school or full-time participation in vocational training, with a lifetime limit of 4 quarters creditable to vocational training.

Effective date.-- The proposal would be effective January 1, 1988.

2. Targeting the Use of the Income and Eligibility Verification System (sec. 10102 of the bill)

Present law.-- Section 1137 of the Social Security Act requires that States establish an income and eligibility verification system (IEVS) for certain public assistance programs. Section 1137 was established by the Deficit Reduction Act of 1984 and was effective April 1, 1985, although the Secretaries of the respective departments may permit States to delay implementation. Such delays may not extend beyond September 30, 1986.

Under IEVS, the State agencies administering AFDC, Medicaid, Unemployment Compensation, Food Stamps and the adult assistance programs in the territories (and the Social Security Administration (SSA) in the case of the SSI program) must request and make use of: (1) unearned income information available from the Internal Revenue Service; and (2) quarterly wage information. Independent verification of the unearned income information is required before action can be taken and recipient confidentiality must be protected.

Explanation of provision.-- The bill clarifies that Congress intends that the system be targeted to those uses which are likely to be most productive.

It is the intent of the Committee to have States utilize a variety of information sources to verify the eligibility of applicants and recipients of benefit programs, as an effective and efficient tool in preventing benefit payments from being made to individuals who are not eligible. For the use of such information to be a productive activity, States must be afforded the discretion to target their efforts in ways they determine most cost effective. The final rules promulgated by the respective Departments do not permit the targeting prescribed in statute. Rather, the final rules call for matching all applicants and recipients against each information source, and require a follow-up in all cases where any income, earned or unearned, is indicated. This universal review was not what was intended by Congress and would result in an unnecessary and costly administrative burden on the States.

To insure that the required matches are cost-effective verification processes, the States should be allowed to prioritize and target the follow-up of case records based on match findings. For example, following-up on individuals whose unearned income exceeds certain tolerance levels is more efficient than verifying every case with unearned income.

In addition, the Committee believes that requiring States to act upon the information they receive within 30 days, as prescribed in the final rule, is unrealistic. States have a finite amount of administrative resources, and are dependent upon the actions of others outside the agency as well as the mail system to carry out their duties. For this reason, the Committee believes a 45 day requirement is more reasonable than the 30 days set forth in the final rule. The allowance that action can be delayed further on up to 20 percent of the information items when collateral verification sources are required -- as provided in the final rules -- should be retained.

Effective date.-- On enactment.

3. Annual Calculation of the Federal Percentage of AFDC Expenditures (sec. 10103 of the bill)

Present law.-- Prior to enactment of Public Law 99-272, the Federal percentage was calculated between October 1 and November 1 of each even-numbered year. The percentage applied to the two year period beginning the following October. P.L. 99-272 requires an annual rather than biennial calculation of the Federal percentage beginning in FY 1987.

Explanation of provision.-- The shift from a biennial to an annual calculation of the Federal percentage occurs in the middle of the two-year cycle and results in a loss of funds for 13 States in FY 1987. The bill restores these funds for FY 1987 only. According to the Department of Health and Human Services, the States affected are: Arizona, Florida, Georgia, Maine, Minnesota, Missouri, New Hampshire, North Carolina, Ohio, Rhode Island, South Carolina, South Dakota, and Virginia.

Effective date.-- October 1, 1986.

4. Extension of that Portion of the Federal Unemployment Tax (FUTA) that is Due to Expire on December 31, 1987 (sec. 10104 of the bill)

Present law.-- Employers pay a FUTA tax of 6.2% on the first $7,000 in wages paid to their employees. They receive a credit, however, of 5.4%, in recognition of the State unemployment taxes that they pay, making the net FUTA tax .8%. A portion of the 6.2% gross FUTA rate, .2%, is temporary and under current economic assumptions will expire on December 31, 1987. This will reduce the net FUTA tax to .6%.

The temporary portion of the FUTA tax was enacted as part of the Unemployment Compensation Amendments of 1976 (P.L. 94-566) and became effective on January 1, 1977. The funds generated by this portion of the tax are used to repay general revenue advances made to the Extended Unemployment Compensation Account. These advances have been used to pay for the Federal Supplemental Benefit program and for the Federal share of the permanent extended benefit program.

Under current law, the tax automatically expires at the beginning of the first year following the year in which the advances are repaid. Current economic projections indicate that advances will be fully repaid in mid-1987. This means that the gross FUTA tax rate will be 6.0%, and the net FUTA tax rate will be .6%, for the year beginning January 1, 1986.

Explanation of provision. -- The bill provides that the temporary FUTA tax would remain in effect for 1988 and 1989, notwithstanding the anticipated repayment in 1987 of general revenue advances to the Extended Unemployment Compensation Account.

Effective date.-- The provision applies to renumeration paid after December 31, 1986.

Subtitle C. -- Medicare and Health Programs

Part 1 -- Provisions Relating to Medicare Part A Only

1. Setting part A deductible at $500 for 1987 (sec. 10201 of the bill)

Present law.--Under current law medicare beneficiaries are required to pay a part A hospital deductible for each hospital admission, but not to exceed one hospital deductible per spell of illness. The part A deductible is tied to a formula based on the annual increase in the average cost per day of hospitalization. The deductible for CY 86 is $492 and is projected to rise to $572 in 1987, $616 in 1988, and $648 in 1989. The part A deductible has increased rapidly as an unforeseen consequence of the shorter lengths of stay that have resulted in part from the implementation of the prospective payment system for hospitals.

Explanation of provision.--For CY 86 the hospital deductible would be $500, thereafter current law would prevail. The Committee believes that the projected increases in the hospital deductible are unacceptably high and will reach levels which were never intended. If the current rate of increase had been allowed, the part A deductible would have gone up 43% over the two years, 1986-1987. For this reason, the Committee has decided to set the deductible at $500 for CY 86 with the thought that it will revisit this issue next year to determine an appropriate rate structure for future years.

Effective date.--The provision is effective for part A hospital deductibles incurred in 1987.

2. Applicable percentage increase in payments for inpatient hospital services (sec. 10202 of the bill)

Present law.--Current law provides that the medicare prospective payment rates be updated annually by the Secretary of Health and Human Services (HHS). The law states that the update should reflect increases in hospital input prices, but not to exceed the hospital market basket (index measuring hospital input prices) for FY 1987 and FY 1988 and market basket plus one quarter of a percentage point thereafter. The Congressional Budget Office baseline for estimating FY 1987 expenditures assumes a 2% increase in payments for PPS hospitals.

On June 30, 1986, the Secretary of HHS promulgated proposed regulations that would provide a .5% increase in the prospective payment rates for FY 1987. The Prospective Payment Assessment Commission (ProPAC) has recommended a 2.2% increase in prospective payment rates for FY 1987 if capital is included into the PPS system, 1.9% if not.

PPS-exempt hospitals are paid on a cost basis subject to caps on the maximum amount of allowable reimbursement. The Secretary of HHS has proposed a .5% increase in the caps of PPS-exempt hospitals while ProPAC has recommended a 3.2% increase.

Current law requires that the DRG weights be recalibrated no less frequently than every four years. Recalibration means the adjustment of all DRG weights to reflect relative resource use associated with all existing DRG categories and/or the creation or elimination of DRG categories.

Explanation of provision.--The bill would require that prospective payment system hospitals be provided a 1.3%

increase in the average standardized payment amounts for fiscal 1987 and market basket minus two percentage points for fiscal 1988.

PPS-exempt hospitals would be provided a 1.3% increase in the cost limits for FY 1987, and an increase of hospital market basket minus 2.0% for FY 1988. In years beyond FY 1988 the bill would indicate that the update factor for PPS hospitals may be established at a different level than the update factor for PPS exempt hospitals. It is the Committee's view that the criteria utilized to develop the update factor for PPS-exempt hospitals should be specific to the operation of these facilities. Therefore, the Committee recommends that the Secretary consider the ProPAC recommendations regarding a separate update factor for PPS-exempt hospitals.

The Committee has given, in the past, a significant amount of discretion to the Secretary of Health and Human Services in developing the annual update factor for hospital payments under the medicare program. The statutory language requires that hospital payments reflect amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality.

The Committee has, however, for the last two years overridden the Administration's recommended update factor. The Committee finds itself in the same situation once again this year as it finds the Secretary's recommended FY 1987 update factor unacceptable. The Committee concludes that the Administration, in developing the update factor for fiscal year 1987 used factors other than those originally anticipated in the legislation.

In response to concerns of the Secretarial use of the discretionary authority granted by Congress, the Committee has reluctantly taken the step of not only mandating the update factor for FY 1987 but also for FY 1988. The Committee requires that the Secretary, for the FY 1988 update factor, provide a report and a documented recommendation to Congress by April 1, 1987, on what the Secretary would recommend for the FY 1988 update factor. The Committee will review this report, along with the report of the Prospective Payment Assessment Commission, and make a determination as to what, if any, adjustments should be made to the FY 1988 update factor established under this legislation at market basket minus two percent.

The Committee anticipates that the Secretary will continue to publish the June 1 proposed regulation for FY 1988, providing for the market basket minus two percent update factor as well as recalibrating and making other adjustments as appropriate and within the scope of the law. The final regulation would be published September 1, 1987, for implementation October 1, 1987.

The Committee believes that the most recent data available should be used in refining the market basket. The market basket is being established on a 1982 data source even though significant changes have taken place since then. Data from 1984 is available and should be used.

The Secretary of HHS would be required to recalibrate the diagnosis related group (DRG) weights annually to ensure that the DRG weights reflect the use of new technologies and other practice pattern changes affecting the relative use of hospital resources among DRG categories.

The Committee is most concerned that the Administration has failed to respond to Congress on the many studies and requests that would identify ways in which the PPS system could be refined to more accurately reflect the costs incurred per discharge. As the movement towards national rates progresses, the need for refinements to the system in order to provide for an equitable distribution of payments among hospitals becomes more urgent. The Committee understands that the Secretary of Health and Human Services has made the PPS studies and refinement issues the highest priority. The Committee further anticipates that work on refining the PPS system will enable consideration of legislation to make the system more equitable during 1987.

The Committee is concerned about the impact of the prospective payment system on rural hospitals. The Committee is also concerned about hospitals in rural areas which are on the margins of qualifying for the urban payment rate. The Committee believes that hospitals in counties that are in this category may be experiencing hardship under the PPS system and would urge that the Secretary examine what options are available to remedy this situation. Furthermore, the Committee is concerned about the impact of the outlier policy on rural hospitals as well as the accuracy of the methodology of establishing the rural/urban payment rates. The Committee will be examining more closely the issue of rural hospitals in the coming year.

Effective date.--The provisions would be effective for cost reporting periods beginning during fiscal years 1987 and 1988 for prospective payment system-exempt hospitals; and for discharges occurring during fiscal years 1987 and 1988 for prospective payment system hospitals.

3. Limitation on payments for capital-related costs for inpatient hospital services of DRG hospitals under medicare (sec. 10203 of the bill)

Present law.--The Social Security Amendments of 1983, P.L. 98-21, implemented a prospective payment system for hospital inpatient operating costs. Under P.L. 98-21, capital-related costs are excluded from the prospective payment system until October 1, 1986. This exclusion was extended until October 1, 1987, by the Urgent Supplemental Appropriations Bill, P.L. 99-369.

If Congress does not enact legislation to include capital-related costs in the prospective payment system by October 1, 1987, medicare payment for such new costs would only be allowed if a State had a capital-expenditure review agreement with the Secretary of HHS (under section 1122 of the Social Security Act) and the State had recommended approval of the expenditure.

The Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272, provides that payment for return on equity capital will be separated from payments from other elements of capital-related costs and phased out over a three year period. For hospital cost reporting periods beginning in fiscal year 1987, payments for return on equity will be reduced to 75% of the otherwise allowable amount. For cost reporting periods during fiscal years 1988 and 1989, return on equity payments will be reduced to 50% and 25% respectively, of the otherwise allowable amounts.

Explanation of provision.--The bill would require the Secretary to ensure that the aggregate payment amount for capital-related costs associated with inpatient hospital services for hospitals under the prospective payment system (PPS) does not exceed the target limits as specified.

The Secretary of HHS would be required to estimate, based upon the best available data, the aggregate amount of payment for capital-related costs associated with inpatient hospital services for PPS hospitals and their exempt units for portions of cost reporting periods occurring in fiscal year 1986. The aggregate amount means the sum of such capital-related expenditures for hospitals under the prospective payment system.

This amount would establish the base on which payments in fiscal years 1987 through 1989 would be determined. The Secretary would be permitted to adjust the fiscal year 1986 base in each of the following fiscal years based on the most recent available data.

In determining the limit on payments in fiscal year 1987, the Secretary would be required to adjust the fiscal year 1986 base. The base would be reduced by an amount equal to 25 percent of the payment for return on equity. The Secretary would be required to ensure that the aggregate amount of such capital-related payments for portions of cost reporting periods occurring in fiscal year 1987 does not exceed 110% of the adjusted fiscal year 1986 base.

The fiscal year 1986 base used for determining the limit on payments in fiscal year 1988 would be reduced by the amount equal to 50% of the payment amount for return on equity. The Secretary would be required to ensure that the aggregate amount of such capital payments for portions of cost reporting periods occurring in fiscal year 1988 does not exceed 120% of the adjusted fiscal year 1986 base.

The fiscal year 1986 base used for determining the limit on payments in fiscal year 1989 would be reduced by an amount equal to 75% of the payment amount for return on equity. The Secretary would be required to ensure that the aggregate amount of such capital expenditures for portions of cost reporting periods in fiscal year 1989 does not exceed 130% of the adjusted fiscal year 1986 base.

If the Secretary determines that the aggregate amount of payment for capital-related costs would exceed the specified limits, the Secretary would be required to determine the necessary capital reduction percentage to ensure that payments do not exceed the specified limits. The Secretary would then reduce payments by the percentage necessary to provide that payments for portions of cost reporting periods in such fiscal years are within the specified limits. The Secretary would be required to determine such percentage based upon the best available data prior to the beginning of the fiscal year involved.

The percentage reduction determined by the Secretary to be necessary to ensure that payments do not exceed the target limits would not be subject to further adjustment in later fiscal years. There would be no judicial review of the percentage reduction factor. Final reconciliation of payments to hospitals would be made on the basis of such percentage.

The current law exclusion of capital-related costs from the prospective payment system until October 1, 1987, would not be changed.

The Secretary would be required to publish in the Federal Register the capital percentage reduction for each fiscal year as a part of the prospective payment regulations proposed in June. For fiscal year 1987, the Secretary would be required to publish the percentage reduction within 30 days after enactment, but no later than October 1, 1986.

The Prospective Payment Assessment Commission would be required to assess the assumptions used by the Secretary in determining the capital reduction percentage and report to Congress.

This provision would not apply to PPS-exempt hospitals or sole community providers.

For purposes of this provision, capital-related costs include those costs as prescribed by the Secretary in regulation. Return-on-equity would be phased out over three years as under present law.

Effective Date.--Enactment

4. Coverage of hospitals in Puerto Rico under DRG Prospective Payment System (sec. 10204 of the bill)

Present law.--Under current law, hospitals located in Puerto Rico are excluded from the prospective payment system and continue to be reimbursed on the basis of reasonable costs.

The Secretary of HHS was required to submit legislative recommendations to Congress with respect to methods for including hospitals located outside of the 50 States (including Puerto Rico) under a prospective payment system. The report was due April 1, 1984, and has not yet been received.

Explanation of provision.--The bill would require the Secretary to include hospitals located in Puerto Rico into a prospective payment system. The prospective payment rate for such hospitals would be equal to 75 percent of the Puerto Rico standardized rate and 25 percent of the national standardized rate.

The national standardized amount for Puerto Rican hospitals would be an equal blend of the rural and urban standardized amounts.

The Secretary would be required to determine a Puerto Rico standardized amount for urban and rural hospitals. The amount would be standardized by excluding an estimate of indirect medical education costs, adjusting for variations among hospitals by area wage levels and adjusting for variations in case mix among hospitals.

An area wage adjustment would be provided to hospitals located in Puerto Rico. Such adjustment would be based on the relative hospital wage level in the hospital's geographic area compared to the Puerto Rican average hospital wage level.

The Secretary would be required to estimate what additional payments will be made under the disproportionate share and outlier provisions and reduce the Puerto Rico average standardized amount to account for such payments.

The Secretary would be prohibited from restandardizing or otherwise adjusting the national standardized rate to reflect the inclusion of Puerto Rico into the prospective payment system.

The following provisions relating to hospitals under the prospective payment system generally, would also apply to hospitals located in Puerto Rico; outlier payments, payments for indirect medical education, payments relating to the cost of certified registered nurse anesthetists, payments relating to disproportionate share and other exceptions and adjustments as determined by the Secretary.

The current law provision under the prospective payment system relating to sole community providers or referral centers would not apply to hospitals located in Puerto Rico.

The Secretary would determine the Puerto Rico standardized rate for fiscal year 1987 by updating the target amount for fiscal year 1986 by the appropriate PPS update factor.

The Secretary would be required to issue regulations, no later than October 1, 1986 as are necessary to implement this provision.

The PPS update factor for hospitals located in Puerto Rico would be the same update factor as for other prospective payment hospitals beginning in fiscal year 1988.

Effective Date.--The provision would be effective with respect to cost reporting periods beginning on or after October 1, 1986.

5. Improving Quality of Care with Respect to Part A Services (sec. 10205 of the bill)

Present Law.--(a) Refinement of the Prospective Payment System--Under the medicare prospective payment system, hospitals are reimbursed on a per case (diagnosis related group - DRG) basis. Payment rates for each DRG reflect the average cost of providing care to patients classified in the DRG.

(b) Requiring Notice of Patient Rights--There is no statutory requirement that a statement of rights be distributed.

(c) Discharge Planning--By regulation, hospitals participating in medicare must have a discharge planning program to facilitate the provision of followup care.

(d) Review of Conditions of Participation--For a hospital to be eligible for medicare reimbursement, the hospital must be in compliance with medicare's conditions of participation for hospitals as set forth in subchapter B of title 42 the Code of Federal Regulations or must be accredited by a national accreditation body, such as the Joint Commission on Accreditation of Hospitals.

(e) Study of Payment of Administratively Necessary Days--Under prospective payment, payment for hospitals is made on a per case basis. No special provision is made for payment of administratively necessary days (ANDs). An AND is a day of continued inpatient hospital stay necessitated by delays in obtaining placement of a patient in a skilled nursing facility (SNF).

(f) Continuation of Favorable Presumption of Waiver of Liability--Under the waiver of liability, payment may be made for services which are not covered because they were not medically necessary or were for custodial care if neither the beneficiary nor the provider knew or could reasonably have been expected to know that the services were not covered for these reasons. By regulation, a home health agency is presumed to meet this test if its denial rate on claims for services is 2.5 percent or less. A SNF is presumed to meet the test if its denial rate is 5.0 percent or less. Hospice providers are not eligible for a favorable presumption.

In a notice dated February 21, 1986, the Secretary issued regulations that eliminated the favorable presumption of the waiver of liability. Payment for noncovered services would have continued on a case-by-case basis. Implementation of the regulation was temporarily blocked by P.L. 99-272. As a result of the law, the favorable presumption will be continued until October 1, 1988, for SNF services. The favorable presumption for home health services will be continued until 12 months after the date on which ten regional intermediaries commence operation as required under Section 1816(e)(4) of the Social Security Act.

(g) Waiver of Liability for Technical Denials for Home Health Services--Beneficiaries who are confined to home and require skilled nursing care on an intermittent basis are eligible for home health services. Intermittent care generally is defined as permitting daily skilled nursing visits of up to eight hours a day for up to two to three weeks. Denials based on homebound and intermittent care requirements are commonly referred to as "technical denials." Under the waiver of liability, payment may be made for services excluded from coverage under Section 1862(a)(1) or (9) of the Social Security Act as unnecessary or as related to custodial care if the provider did not know and could not be expected to have known that payment would be denied for these reasons. The waiver of liability does not apply to technical denials.

(h) Development of Uniform Needs Assessment--Current law contains no provision.

(i) Expedited Review by Fiscal Intermediaries--Claims for hospice, home health, and SNF services generally are reviewed on a retrospective basis after the services are provided. Current law does not provide effective standards for timeliness in claims submission and review.

(j) Including Information in PPS Annual Reports--The Secretary is required to submit annual reports to Congress concerning the prospective payment system.

(k) Prior Authorization Demonstration Project--Medicare fiscal intermediaries have responsibility for deciding whether payment will be made for services provided by home health agencies and SNFs. Generally, these payment decisions are made on a retrospective basis after services are provided.

Explanation of Provision.--(a) Refinement of the Prospective Payment System--A number of studies have shown that, because of technical limitations with the DRGs, costs are substantially higher than the DRG payment for some patients. In other cases, costs are substantially less. As a result of these limitations, hospitals which provide care to a more severely ill patient population may receive insufficient reimbursement. Even if total payments to a hospital during a year approximate costs of providing necessary care, hospitals may have incentives to inappropriately reduce services in an attempt to increase net revenues if payments and costs diverge substantially in individual cases. For these reasons, the Committee believes that there is a need to improve the case mix measurement system used in determining prospective payments for hospitals.

The Secretary would be required to submit a legislative proposal to improve the prospective payment system. The proposal should assure that per case payments approximate the cost of providing medically necessary care in an efficient manner for individual patients or classes of patients with similar conditions. The proposal should account for variations in severity of illness and case complexity which are not adequately accounted for by the DRGs; however, use of a severity of illness index is not specifically required. The report is due no later than 2 years after enactment.

(b) Requiring Notice of Patient Rights--The medicare provider agreement with hospitals would be amended to require that hospitals provide a notice of patient rights to beneficiaries at the time of hospital admission. The notice would include information concerning: (i) rights to inpatient and post-hospital care under medicare; (ii) financial liability for continued inpatient stay if a hospital serves notice that further inpatient care is no longer necessary; (iii) rights to appeal such a notice; (iv) financial liability for continued stay if the appeal is unsuccessful; and (v) other such information as the Secretary of Health and Human Services deems appropriate. It is the Committee's intent that the statement of rights be written in terms easily understood by the elderly. The Committee also intends that the statement of rights be provided in translation to non-English speaking beneficiaries.

(c) Discharge Planning--The Committee believes that sound discharge planning is essential to ensuring a safe transition after discharge from an acute care setting. The need for effective discharge planning has increased because the average length of hospital stay for beneficiaries has shortened significantly partly as a result of the prospective payment system and other changes in the health care system. Accordingly, the Committee has adopted a provision that would establish a set of minimum standards for discharge planning that must be satisfied for a hospital to participate in medicare.

Under the provision, hospitals would be required to provide a discharge planning evaluation for beneficiaries who are hospital inpatients: (i) upon request of the patient or attending physician; and (ii) for other patients likely to suffer adverse health consequences after discharge in the absence of discharge planning. The required evaluation would include an assessment of the patient's need for post-hospital services and the availability of those services. The conclusions of the discharge planning evaluation would be made available to the patient and the attending physician to assist in the development of a final discharge plan. Discharge planning would be performed by, or under the supervision of, a registered nurse, social worker, or other appropriately qualified personnel. The requirements could not be satisfied by accreditation by a national accreditation body acting pursuant to Section 1865(b) of the Social Security Act unless the Secretary determines the discharge planning requirements of the accreditation body are at least as rigorous as those required by this provision.

(d) Review of Conditions of Participation--The Secretary would be required to arrange for a study of the standards used to qualify hospitals for participation in medicare. The purpose of the study would be to determine whether the standards are adequate to ensure quality of care. Enactment of the prospective payment system in 1983 has changed financial incentives for hospitals in a fundamental way. While the overall effect of the new incentives has been positive, there exists a possibility that hospitals might inappropriately reduce essential services to increase net revenues. The Committee believes that rigorous and detailed quality assurance standards are essential to safeguard against this possibility. Accordingly, the Committee believes that a review of the standards used to qualify hospitals for participation in medicare is appropriate at this time.

The Committee recognizes that the Secretary recently completed a review of medicare's conditions of participation for hospitals and issued final regulations changing these conditions in June of this year. This review was initiated by the Secretary in 1980 before enactment of the prospective payment system, and the purpose of the review was to simplify the conditions of participation to provide maximum flexibility for providers. Because the review was not focused on the possible need to strengthen quality assurance mechanisms to serve as a counterbalance to the incentives inherent in prospective payment, the Committee believes that the recently completed review is not sufficient to satisfy the Committee's concerns.

The Committee intends that the study encompass both medicare's conditions of participation for hospitals as set forth at 42 C.F.R. subchapter B and the standards used by national accreditation bodies recognized by the Secretary, such as the Joint Commission on Accreditation (JCAH) and the American Osteopathic Association (AOA). The Committee notes that about 5,000 hospitals are qualified to participate in medicare by virtue of accreditation by the JCAH or AOA. These hospitals are not directly subject to the conditions of participation that appear in regulation. Only about 1,000 hospitals are directly subject to the regulatory conditions of participation. Thus, there is a clear need to review both the regulatory standards and standards established by national accreditation bodies. It is the Committee's intent that the Secretary consult with a wide variety of experts in quality assurance and with representatives of providers, physicians, and consumers in conducting the study. The study would be due within 2 years after enactment.

(e) Study of Payment of Administratively Necessary Days--Under the prospective payment system, hospitals receive a fixed per case payment irrespective of actual length of stay. A hospital which is unable to discharge a beneficiary because of difficulties in obtaining placement for the beneficiary in a SNF may be reimbursed less than costs if substantial delays in discharge result. Although payment for these administratively necessary days has been included in the prospective payment system rates, these payments may be insufficient in some situations. Accordingly, it has been suggested that a separate payment be made for administratively necessary days (ANDs), that is, for additional days of inpatient hospital care necessitated by delays in obtaining SNF placement. Because of the complexity of the issues involved in implementing an AND payment system, the Committee believes that the advisability of making payments for ANDs should be carefully studied.

Under the provision adopted by the Committee, the Secretary would be required to conduct a study to determine whether payment should be made for ANDs. Such a payment would be separate from the per discharge and outlier payments made under prospective payment. The Secretary would be required to consider whether payment for ANDs is needed to minimize the potential for a disproportionate financial impact of prospective payment on hospitals located in areas where there is a shortage of nursing home beds. The Secretary would also be required to consider the potential for inappropriate payments for ANDs and the practicality and effectiveness of administrative mechanisms that could be used to prevent inappropriate payments. The report would be due by January 1, 1988.

(f) Continuation of Favorable Presumption of the Waiver of Liability--The Committee believes that it is appropriate to extend certain rules related to the waiver of liablity for home health and SNF services by an additional year, to October 1, 1989. During the interval, the Secretary would be required to conduct a demonstration of a prior authorization system for home health and SNF services. After completion of the demonstration project, the Committee believes that it may be appropriate to consider either a further extension of current policy concerning the waiver or replacement of the waiver (in whole or in part) by a prior authorization system.

Under the proposal, a favorable presumption regarding the waiver of liability would be available to qualified hospice, home health, and SNF providers until October 1, 1989. Hospice providers having 2.5% or fewer claims denied on the basis of Section 1862(a)(1) or (9) of the Social Security Act would qualify. Current standards for home health and SNF providers would continue to apply.

(g) Waiver of Liability for Technical Denials for Home Health Services--The Committee notes that there is a considerable degree of uncertainty concerning standards for application of the homebound and intermittent care requirements for home health services. As a result of this uncertainty, a home health agency, acting in good faith and believing that the beneficiary satisfies the applicable standards, may provide costly services to a beneficiary only to find that payment has been denied after the fact.

To protect providers acting in good faith and to improve access to needed home health services, the Committee would extend the waiver of liability to allow for payment of home health services if the provider did not know and could not have been expected to know that payment would be denied based on a determination that the individual was not homebound or did not require skilled nursing care on an intermittent basis. A home health agency would be presumed to be without knowledge regarding these facts if no more than 2.5 percent of the claims submitted by the agency during the previous quarter were denied on the basis of homebound or intermittent care requirements. The favorable presumption provision would expire on October 1, 1989.

(h) Development of Uniform Needs Assessment Instrument--The Secretary of Health and Human Services would be required to develop a uniform needs assessment instrument to be used by discharge planners, providers, and fiscal intermediaries in evaluating an individual's need for hospice, home health, and skilled nursing facility (SNF) services, and other long-term care services of a health-related or supportive nature. An advisory panel would be established for consultation with the Secretary. The Secretary would be required to submit a report to Congress concerning the needs assessment instrument no later than 1 year after enactment. The report would include an evaluation of the instrument and the advantages and disadvantages of using the instrument for determining whether payment should be made for hospice, home health, and SNF services provided to beneficiaries.

(i) Expedited Review by Fiscal Intermediaries--Reimbursement determinations for hospice, home health, SNF services are made by fiscal intermediaries on a retrospective basis after services have been provided. Because these services generally are provided on an ongoing basis, delays in claims processing can lead to substantial financial burdens for providers if payment is denied. Current law does not establish effective standards for timeliness of claims review. In some situations, there can be a delay of up to 3 months or more between initial provision of services and first notification of the provider by the fiscal intermediary concerning coverage and reimbursement.

The Committee believes that this delay creates an unacceptable burden on hospice, home health, and SNF providers. Accordingly, under the provision adopted by the Committee, the Secretary would be required to develop procedures to expedite the claims review process for hospice, home health, and SNF services to minimize the delay between initiation of services and first notice from the intermediary to the provider as to whether payment will be made.

(j) Including Information in PPS Annual Reports--The annual reports to Congress would be expanded to include: (i) an evaluation of the adequacy of procedures for assuring the quality of post-hospital services provided under medicare; (ii) an assessment of problems that have prevented beneficiaries from receiving appropriate post-hospital services; and (iii) information concerning reconsiderations and appeals for post-hospital services covered under medicare.

(k) Prior Authorization Demonstration Project--The Secretary would be required to conduct a series of demonstration projects related to prior authorization of home health and SNF services. The purpose of the demonstration would be to demonstrate the feasibility of a prior authorization system and to evaluate prior authorization as an alternative to the current system of retrospective review.

Effective Date.--Paragraphs (a), (d), (e), (h), (j), and (k) would be effective on enactment. Paragraph (b) would be effective no later than eight months after enactment. Paragraph (c) would apply to hospital provider agreements no later than 1 year after enactment. Paragraphs (f) and (g) have varying effective dates. Paragraph (i) would be effective one year after enactment.

6. Off-budget treatment of federal hospital insurance trust fund in fiscal year 1987 (sec. 10206 of the bill)

Present Law.--Under current law the Federal Hospital Insurance Trust Fund (HI) receipts and disbursements are included in the unified budget until fiscal year 1993. In 1993 the HI Trust Fund will be removed from the unified budget. Under the Balanced Budget and Emergency Deficit Control Act of 1985, the Old-Age and Survivors and Disability Insurance Trust Funds (OASDI) were removed from the unified budget for fiscal year 1986 and beyond. However, the disbursements and expenditures of these two trust funds are included for purposes of determining whether the deficit exceeds the "maximum deficit amount" targets set in law.

Explanation of provision.--The Committee is concerned that as a result of the Balanced Budget and Emergency Deficit Control Act of 1985 the Hospital Insurance Trust Fund is treated differently for budget purposes than the Old-Age and Survivors and Disability Insurance Trust Fund. To preserve the historic relationship of the three trust funds for budget purposes, the bill would accelerate from fiscal year 1993 to fiscal year 1987 the effective date of the provision of the Social Security Act that removes the receipts and disbursements of the Federal Hospital Insurance Trust Fund (HI) from the unified budget presented by the President and considered by the Congress. The Committee bill would provide for the HI and OASDI trust funds to be treated the same under the Balanced Budget and Emergency Deficit Control Act of 1985. The disbursements and expenditures of all three trust funds would be included for purposes of determining whether the deficit exceeds the "maximum deficit amount" targets set in law.

Effective date.--The provision is effective beginning October 1, 1986.

7. Technical amendments and miscellaneous provisions relating to part A (sec. 10207 of the bill)

Present Law.--(a) One year extension of pass-through for costs of certified registered nurse anesthetists--Under current law the costs of certified registered nurse anesthetists are passed through on a cost basis for PPS hospitals until October 1, 1987.

(b) Four-year designation period for rural referral centers--Under current law a rural hospital will be considered a rural referral center if it has at least 500 beds and meets other requirements. Under regulations, once a rural referral center has achieved referral status, it will be paid at the applicable urban rate for a three year period.

(c) Temporary waiver of inpatient limitations for Connecticut Hospice, Inc.--Current law requires that medicare-certified hospices maintain no more than 20% of total

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days as inpatient days. Connecticut Hospice, Inc. currently has waivers of virtually all the medicare requirements but the waivers expire on October 1, 1986.

(d) Massachusetts medicare repayment--Massachusetts operated a State-wide hospital demonstration project from October 1, 1982 through June 30, 1986. The effectiveness of the state system is judged by the Secretary to ensure that medicare expenditures under the demonstration are not greater than they would have been under medicare regular reimbursement rules. The Secretary of HHS has determined, based upon unaudited data, that medicare overpayments were made during the first two years of the Massachusetts waiver. As a result the Secretary has established a repayment schedule for the "overpayments".

(e) Technical and other miscellaneous provisions--Current law contains a number of technical errors.

Explanation of Provision.--(a) One-year extension of pass-through for costs of certified registered nurse anesthetists--The bill would extend by one year the pass-through for costs of certified registered nurse anesthetists.

(b) Four-year designation period for rural referral centers--Hospitals currently with rural referral status under the PPS system would receive payment at the urban rate for a four year period rather than for a three year period. After the fourth year, each such hospital would be required to demonstrate that it continues to meet the criteria established by the Secretary. The Secretary would be prevented from terminating such classification before the end of the hospital's fourth cost reporting period.

(c) Temporary waiver of inpatient limitations for the Connecticut Hospice, Inc.--Connecticut Hospice, Inc. would receive a waiver of the inpatient day requirement for a two year period provided that the proportion of inpatient days does not exceed 50%. The waiver would not be extended beyond this period.

(d) Massachusetts Medicare Repayment--The bill would prevent the Secretary from further recouping or otherwise reducing payments for these hospitals until January 1, 1988. The bill would not change any payment amounts that may become due.

(e) Technical and other miscellaneous amendments--(1) Correct and clarify section regarding payments under the indirect teaching adjustment;

(2) Correct and clarify section regarding payments under the disproportionate share provision;

(3) Clarify that all hospitals which have a medicare provider agreement would have to abide by the emergency care requirements;

(4) Allow SNFs to make election to be paid on a prospective payment basis based on their cost reporting periods rather than on a Federal fiscal year basis;

(5) Clarify that the Medicare (HI) tax on state and local government does not apply to certain campaign workers; and

(6) Make other miscellaneous corrections to COBRA and related laws.

Effective Date.--

(a) October 1, 1987

(b) Enactment

(c) Enactment

(d) Enactment

(e) The provisions would be effective as if they had been included in the enactment of the laws they amend.

Part 2 -- Provisions Relating to Parts A and B

1. Elimination of periodic interim payment system (PIP) for DRG hospitals and prompt payment for medicare providers (sec. 10221 of the bill)

Present law.--(a) Periodic interim payment system--There are no current law requirements concerning periodic interim payments to providers. By regulation, the Health Care Financing Administration (HCFA) allows providers (hospitals, skilled nursing facilities, home health agencies and hospices) that elect such payments and which meet specified guidelines, the option of receiving periodic interim payments (PIP) every two weeks. The payments are based on an estimate of how much the medicare program owes the provider. Overpayments/underpayments are settled quarterly. HCFA has proposed eliminating PIP as an option for all hospitals, skilled nursing facilities, hospices and home health agencies effective July 1, 1987.

(b) Prompt payment for medicare providers--There are no current law requirements concerning prompt payment of claims. Historically, medicare has processed both part A and part B claims in a timely manner. HCFA has recently slowed down the average processing time for part A claims from an average of 9 days in the beginning of FY 1985 to an anticipated 27 days at the end of FY 1986; and for part B claims from 11 days in the beginning of FY 1985 to an anticipated 27 days at the end of FY 1986.

Explanation of provision.--(a) Periodic interim payment system--The periodic interim payment option would be eliminated for inpatient hospital services provided in PPS hospitals and exempt units of PPS hospitals, except for services provided in "disproportionate share" hospitals, sole community hospitals, and hospitals in States holding waivers under Section 1886(c) or Section 1814(b)(3). Cost-based providers could continue to receive PIP payments, at their election as under current regulations.

The Committee understands that the Administration believes that regular periodic interim payments to providers are inconsistent with the prospective payment system. While reimbursement on a cost-basis requires that approximations of medicare payments be calculated pending the completion of each cost-accounting year, the prospective payment system is not dependent on this reporting method.

However, because the Committee recognizes that elimination of periodic interim payments may present serious financial difficulties for certain hospitals, the Secretary would be required to permit payment on a periodic interim basis to hospitals to which the above exception applies, using a mechanism that is comparable to that which is currently in place under 42 CFR 405.454(j). In addition, the Secretary would be required to make available accelerated payments to hospitals if the hospital can demonstrate that it is experiencing significant cash flow difficulties resulting from the operations of the fiscal intermediary or unusual circumstances of the hospital operations.

(b) Prompt payment for medicare providers.--Prompt payment of medicare claims would be required. "Clean" claims (i.e., claims which are free of any defect or impropriety, including the lack of any required substantiating documentation, such as incomplete or erroneous entries, and do not require special treatment, such as medical review, preventing timely payment) submitted for payment of services covered under medicare part A would be required to be paid within 22 calendar days of receipt by the medicare intermediary. If the claim is not "clean" and for that reason cannot be paid within the required time period, a notice would have to be sent to the provider who submitted the claim to inform them of expected delays.

"Clean" claims (meeting the definition described in the preceding paragraph) submitted for payment for services covered under medicare part B and provided by nonparticipating physicians and suppliers would be required to be paid within 22 calendar days of receipt by the medicare carrier. "Clean" claims submitted by participating physicians and suppliers would be required to be paid within 11 days of receipt by the medicare carrier. If the claim is not "clean" and for that reason cannot be paid within the required time period, a notice would have to be sent to the physician, supplier or beneficiary who submitted the claim to inform them of expected delays.

In the case of both part A and part B claims, if the claim is not paid and a notice is not mailed within the required time period, interest would begin to accrue (to the provider, physician, supplier or beneficiary) beginning on the day following the day payment or notice was due, and ending on the date on which payment is mailed or the date the notice is provided.

Interest payments would be made using funds otherwise available for federal administration of the medicare program, excluding those funds available for medicare contractor activities. In the Committee's view, it should rarely, if ever, be necessary for interest payments to be made on medicare claims. However, because the Health Care Financing Administration has previously issued instructions to medicare intermediaries and carriers requiring that claims processing be intentionally delayed, the Committee believes that any necessary interest payments which result from a failure to comply with requirements of this provision should be paid by the agency responsible for the implementation of this statute.

Historically, timely payment of medicare claims has not been a significant issue. However, a virtual tripling of claims processing time within two years coupled with budgetary constraints has lead to a significant cash flow problem for providers and medicare beneficiaries. The expansion of medical and utilization review activities has compounded the problem. While the Committee recognizes the value of and the need for medical and utilization review, it does not intend that such review activities lead to unreasonable delays in claims processing. Efforts should be made to alleviate the financial difficulties faced by providers of services where a significant portion of those services have been targeted for medical or utilization review.

The Committee has provided for payment of claims submitted by participating physicians and suppliers within 11 days with the hope of providing an additional incentive for physicians and suppliers to participate in the medicare program. The Committee recognizes that payment delays by the medicare program can discourage participation, and would hope to strengthen the medicare participation program by adopting stricter payment standards.

Effective date.--The elimination of periodic interim payments to prospective payment system hospitals and their exempt-units would be effective with respect to discharges occurring on or after July 1, 1987. Prompt payment of part A claims would be effective for claims received on or after July 1, 1987. Prompt payment of part B claims would be effective for claims received on or after October 1, 1987.

2. Health Maintenance Organizations and Competitive Medical Plans (sec. 10222 of the bill)

Present Law.--(a) Repeal of "two for one" conversion requirement for certain health maintenance organizations--Under current law health maintenance organizations (HMO's) that had or have a medicare cost contract but which sign a medicare section 1876 risk contract must enroll two new medicare risk contract enrollees before they can convert one cost contract member. The purpose of the "two for one" conversion requirement was to limit the cost of the new risk contract provision.

(b) Require the provision of explanation of enrollee rights--There are no specific provisions relating to disclosure of benefits, services and patient rights to medicare beneficiaries enrolling in an HMO.

(c) Restricting waiver of requirement of 50 percent non-medicare enrollment--An HMO providing services to medicare enrollees under a section 1876 risk contract is required to maintain an enrollment consisting of no more than 50 percent medicare and medicaid beneficiaries. The Secretary of HHS has authority to waive the 50% non-medicare/medicaid enrollment standard if special circumstances warrant the waiver and if the HMO is making reasonable efforts to correct the deficiency.

(d) Requiring prompt payment of claims--There are no provisions concerning prompt payment of claims under current law.

(e) Requiring access to financial records and disclosure of internal loans--Section 1866(b) of the Social Security Act permits termination of a provider agreement where the Secretary has not been given access to certain information pertaining to persons or entities subcontracting with the provider. Under current law, there is no requirement of disclosure of "insider transactions" such as loans to related parties or organizations.

(f) Authority to impose civil money penalties--Section 1128A of the Social Security Act imposes civil money penalties on any person making certain improper claims with respect to the provision of medical items or services. The penalties include assessments up to $2,000 per item or service and double the amount claimed in lieu of damages. Rights to notice, hearing and judicial review are set forth in the law.

(g) Study of AAPCC and ACR--HMO/CMP's are reimbursed on a monthly basis an amount per enrolled beneficiary, based on the average cost of providing services to similarly situated beneficiaries in the fee-for-service sector. Reimbursement is in the amount of 95 percent of the adjusted average per capita cost (AAPCC). The HMO/CMP is required to provide to the beneficiary a benefit package at least equivalent to the medicare benefit package. The HMO/CMP is required to develop an adjusted community rate (ACR) which reflects the HMO/CMP's standard charge for its non-medicare enrollees, adjusted to reflect the higher utilization and cost experience of the medicare population. If the AAPCC is in excess of the ACR, the HMO is required to return the difference to medicare or to develop a benefit package to provide additional services or reduced cost sharing.

(h) Allowing medicare beneficiaries to disenroll at a local Social Security Office--Under current law, enrollment and disenrollment procedures are administered by the HMO.

Explanation of provision.--(a) Repeal of "2 for 1" conversion requirement for certain health maintenance organizations. The bill would repeal the "two for one" requirement. The Committee believes that the "two for one" requirement adversely affects those medicare enrollees enrolled in an HMO who cannot convert to the risk contract because they cannot share in the additional benefits package provided to risk contract beneficiaries enrolled in the same HMO. Furthermore, in some cases it may be burdensome on HMO's by placing them in a less competitive situation.

(b) Requiring the provision of explanation of enrollee rights--All HMO/CMP's would be required to provide medicare beneficiaries an explanation of their rights as HMO enrolless, including but not limited to understandable descriptions of the benefits package, the meaning of any "lock-in" provisions, the scope of out-of-area coverage and emergency and urgently needed services and appeal rights. This information would be supplied to beneficiaries enrolled in risk contract HMO/CMP's in Januray 1987 and no less than annually thereafter.

(c) Restricting waiver of requirement of 50 percent non-medicare enrollment--No new waivers of current rule requiring that no more than 50 percent of enrollees be medicare or medicaid eligible would be granted other than for reasons of "disproportionate" representation of medicare and medicaid eligibles in the HMO/CMP service area. Where an existing waiver has been granted for reasons other than "disproportionate" representation, the Secretary must establish a schedule under which each waivered HMO/CMP can meet the 50/50 requirement. Where a waiver has been granted for reasons other than for "disproportionate" representation, the waivers may only be extended if the Secretary determines that the organization (or its successor) has made and is continuing to make reasonable efforts to meet scheduled enrollment goals approved by the Secretary. The Secretary would be given authority to suspend further medicare enrollment if the waivered HMO/CMP fails to meet its enrollment schedule (in order to come into compliance with the 50/50 rule). If the HMO/CMP does not have a 50/50 waiver, but is out of compliance with the 50/50 rule, the Secretary would be permitted to freeze new medicare enrollment.

(d) Requiring prompt payment of claims--the Committee believes that risk-basis HMO/CMP's should meet the same prompt payment standards for claims payment as will be applied to the rest of medicare (i.e. properly submitted claims must be paid within 22 days). Thus, consistent with other sections of this bill, risk-based HMO/CMP's will be required to pay "clean" claims within 22 days, except where the HMO/CMP is under contract with the claimant. In instances where a contract exists between the HMO/CMP and the physician, hospital, or other claimant, the terms of the contract shall govern, and this provision shall not apply. Interest would be due on "clean" claims not paid on a timely basis. The Secretary would be given the authority, after notice and hearing, to provide direct payment to providers and suppliers in cases where the HMO/CMP has failed to meet its financial obligations and to make appropriate adjustments to the HMO's payment rate to reflect such payments.

(e) Requiring access to financial records and disclosure of internal loans--The amendment would require HMO/CMP's to provide the Secretary, upon request, access to books and records of certian subcontractors. In addition, HMO/CMP's would be required to notifiy the Secretary of loans and other special financial arrangements which are made between the organization and subcontractors, affiliates and related parties.

(f) Authority to impose civil money penalties--Section 1128A would be amended to give the Secretary the authority to impose civil monetary penalties, not to exceed $2,000 per violation, in cases where an entity providing items and services as an eligible organization under a section 1876 risk-sharing contract has failed substantially to provide medically necessary items and services that are required (under law or such contract) to be provided to individuals covered under the risk-sharing contract, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) these individuals. The organization would be provided an opportunity to appeal a determination under the guidelines set forth in Section 1128A(b)(2).

(g) Study of AAPCC and ACR--The Secretary would be required to contract with an appropriate organization to study methods by which the adjusted average per capita cost (AAPCC) can be refined to more accurately reflect the average cost of providing care to different classes of patients (e.g. inclusion of variables such as activities of daily living, prior utilization history). The study would also include an assessment of mechanisms which could be developed to refine the Adjusted Community Rate (ACR). The Secretary would be required to submit legislative recommendations on methods by which the calculation of the AAPCC and the ACR may be refined by January 1, 1988.

(h) Allow Beneficiaries to Disenroll from an HMO at a Local Social Security Office--The amendment would require the Secretary to expand disenrollment procedures to permit medicare beneficiaries to disenroll at their local Social Security office.

Effective date.--January 1, 1987.

3. Provisions relating to improvement of quality of care (sec. 10223 of the bill)

Present Law.--(a) Provider representation of beneficiaries on appeals and appeal of technical denials--If a beneficiary disagrees with a payment denial for services provided under medicare part A, he or she is entitled to appeal the determination. Since the inception of the medicare program, beneficiaries have been permitted to be represented in their appeals by the provider who furnished the services in question. In April, 1984, HCPA issued an intermediary manual instruction prohibiting such representation. HCPA also has prohibited appeals of "technical" denials, apparently based on the view that current law does not allow for appeals of these determinations. The denials which have been subject to restrictive rules involve homebound and intermittent care requirements for home health services.

(b) Prohibition of physician incentive plans--Incentive payments to physicians to reduce or limit services provided to beneficiaries are not prohibited under current law.

(c) Study to develop a strategy for quality review and assurance--There is no provision in current law.

Explanation of Provision.--(a) Provider representation of beneficiaries on appeals and appeal of technical denials--Providers would be allowed to represent beneficiaries on appeals. To avoid possible conflicts of interest, the provider would be prohibited from representing the beneficiary with respect to issues that concern the beneficiary's possible obligation to pay the provider for services not covered by medicare. Beneficiaries would have a right to appeal any payment denial for home health services, including denials based on homebound or intermittent care requirements.

(b) Prohibition of physician incentive plans--Incentive payments to a physician by a hospital, health maintenance organization (HMO), or competitive medical plan (CMP) as an inducement to reduce or limit services to beneficiaries under the care of the physician would be prohibited. The Committee believes that such incentive payments may create a conflict of interest that may limit the ability of the physician to exercise independent professional judgment in the best interest of his or her patients.

The Committee recognizes that incentive arrangements are necessary to the operation of some types of HMOs or CMPs. The Committee also recognizes that many of these arrangements pose no inherent threat to quality of care. In particular, many HMOs and CMPs have incentive plans which allow physicians to share in an overall operating surplus or in a favorable variance in the organization's overall financial plan in relation to forecast. Under this type of plan, there is no direct link between a physician's treatment decision and the amount of any bonus received. In contrast, under other arrangements, especially those that do not involve any risk-sharing among physicians, there may be a direct link between treatment decisions and bonus payments. Furthermore, the magnitude of the incentives provided may be so great as to threaten the ability of the physician to exercise independent professional judgment. Thus, the Committee believes that some incentive arrangements should be allowed while others should be prohibited.

Because of the wide variety and complexity of compensation arrangements offered by HMOs and CMPs, the Committee decided that a comprehensive study is needed before establishing exceptions to the general prohibition. Accordingly, the provision has a delayed effective date of January 1, 1988 as it applies to HMOs and CMPs. In addition, the provision requires the Secretary to submit a report to Congress by April 1, 1987 concerning appropriate exceptions to the prohibition for HMOs and CMPs.

The Committee notes that the prohibition only applies to physicians with direct patient care responsibilities. It is the Committee's intent that the prohibition not apply to hospital incentive arrangements with physicians who have a management or supervisory responsibility with respect to the operation of a hospital department (such as radiology or clinical laboratory services) insofar as the purpose of the arrangement is limited to encouraging efficiency in the operation of the department. The prohibition also would not apply to a physician who provides ancillary services under contract to a hospital.

Hospitals, HMOs, and CMPs that knowingly violate the provision would be subject to civil monetary penalties of up to $2,000 for each patient with respect to whom an incentive payment was made. Physicians who knowingly accept prohibited payments would be subject to penalties of up to $2,000 for each patient.

(c) Study to develop a strategy for quality review and assurance--The Secretary would be required to contract with the Institute of Medicine to conduct a major study concerning quality of care. The study would consider a number of issues including the adequacy of current methods for measuring, reviewing, and assuring quality of care and the adequacy of methods available to correct identified quality of care problems. The study would be due 2 years after enactment.

Effective Date.--Paragraph (a) is effective on enactment.

Paragraph (b) is effective 6 months after enactment as it pertains to incentive payments made by hospitals and on January 1, 1988 as it pertains to incentive payments made by HMOs and CMPs. Paragraph (c) is effective on enactment.

4. Technical amendments and miscellaneous provisions relating to parts A and B (sec. 10224 of the bill)

Present Law.--(a) Treatment of group purchasing agreements--Current law prohibits any person from receiving, giving, soliciting or offering any renumeration in return for referring or arranging for the furnishing of any item or service or in return for purchasing, leasing, or ordering any good, facility, or service for which payment can be made under medicare.

Hospitals and other providers have purchased medical supplies and equipment through their participation in group purchasing organizations (GPOs). GPOs purchase goods and services for participating institutions. A service or transactional fee is charged to participating institutions by GPOs. In some situations, these fees are paid by the vendor on behalf of the hospital or other provider.

This practice constitutes a technical violation of medicare anti-fraud and abuse provisions.

(b) Extension and clarification of competitive contracting authority--The Deficit Reduction Act of 1984 provided the Secretary with the authority to enter into two competitively bid contracts under part A and two such contracts under part B to replace poor performing contractors. This authority expires on September 30, 1986.

While the Secretary has used this authority to enter into competitively bid cost contracts, competitive bidding has not been used in the negotiation of fixed-price contracts.

(c) Consolidated Omnibus Budget Reconciliation Act technical corrections--Current law contains a number of technical errors.

Explanation of provision.--(a) Treatment of group purchasing agreements--The bill would legalize the payment of administrative fees to GPOs by vendors for goods and services that may be paid for by medicare but only where full disclosure of such payment is made.

(b) Extension and clarification of competitive contracting authority--The proposal would extend the Secretary's authority to enter into competitively bid contracts for three years and clarify language to include fixed-price contracting.

(c) Consolidated Omnibus Budget Reconciliation Act technical corrections--The bill would: (1) Clarify that a one-year transition period is provided for foreign medical graduates (FMGs) who have not passed the FMGEMS. From July 1, 1986 through June 30, 1987 such an FMG will be counted as a resident at a rate equal to one-half of the rate at which the individual would otherwise be counted;

(2) Allow the Secretary to announce HMO/CMP rates by September 7 of each year rather than publish;

(3) Clarify effective date of the provision regarding penalties for billing for assistants at surgery for certain cataract operations;

(4) Allow temporary use of carrier prepayment screening as a substitute for preprocedure review;

(5) Clarify that the termination date of access demonstration project is July 31, 1987; and

(6) Correct other miscellaneous provisions.

Effective Date.--(a) The provision would apply to payments made before, on or after the date of enactment.

(b) The provision would be effective for contracts entered into on or after October 1, 1986.

(c) The provision would be effective as if it had been included in the enactment of the COBRA.

Part 3 -- Provisions Relating to Medicare Part B

1. Extension of premium payment provision through 1989 (sec. 10231 of the bill)

Present Law.--The Secretary is required to calculate and announce each September the amount of the monthly premium that will be charged in the following calendar year for individuals enrolled in the Supplemental Medical Insurance (part B) portion of medicare. The Secretary is required to calculate the premium amount so as to produce premium income equal to 25% of program costs for enrollees age 65 and over. The annual increase in the part B premium cannot exceed the rate of increase in the cost-of-living adjustment for the social security program. This provision has been in place since 1973.

Beginning in 1989, the premium calculation would revert to an earlier method under which the premium amount is the lower of: (1) an amount sufficient to cover one-half of program costs for the aged; or (2) the current premium amount increased by the percentage by which cash benefits were most recently increased under the cost-of-living adjustment (COLA) provisions of the social security program.

Explanation of provision.--The bill would extend the current law requirement whereby the portion of part B program costs financed by premium income equals 25% for one additional year, through CY 1989. If there is no social security cost-of-living adjustment, the monthly premium would not be increased that year.

Effective Date.--The provision would be effective on enactment.

2. Payment for physicians' services, restrictions on reasonable charge limitation and incentives for physician participation (sec. 10232 of the bill)

Present Law.--(a) Extend and modify limits on physician fee increases-- Medicare pays for physicians' services on the basis of medicare-determined "reasonable charges", the lower of a physician's billed charge, the charge customarily made by the physician, or the prevailing charge limit. Customary and prevailing charges generally are updated annually.

Annual increases in prevailing charge levels are limited by the Medicare Economic Index (MEI) which reflects general inflation and changes in physicians' office practice costs. The prevailing charge for a service as used for payment purposes is the lower of the 75th percentile of customary charges for the service in the area, or the unadjusted prevailing charge in a base year increased by the MEI.

The Deficit Reduction Act of 1984 (P.L. 98-369) froze medicare payments for all physicians for the 15-month period beginning July 1, 1984, and established the participating physician program. Participating physicians were allowed to increase their actual charges. Nonparticipating physicians were prohibited from increasing their charges above April-June 1984 levels. A participating physician is a physician who agrees to accept medicare assignment on all services. Nonparticipating physicians are free to accept or refuse assignment on a claim-by-claim basis.

The freeze on payments was extended through April 30, 1986, by emergency legislation. Under the Consolidated Omnibus Budget Reconciliation Amendments (COBRA) of 1985 (P.L. 99-277), on May 1, 1986, participating physicians received a prevailing charge increase of 3.15% plus an additional 1% increase.

The freeze on actual, customary, and prevailing charges for nonparticipating physicians was extended through December 31, 1986. COBRA established one set of maximum allowable prevailing charges for participating physicians and another set for nonparticipating physicians. Under current law, participating and nonparticipating physicians will receive a customary and prevailing charge update on January 1, 1987. Participating physicians would receive an estimated 3.2% prevailing charge increase based on the MEI for 1987; nonparticipating physicians would receive a 3.15% increase based on the MEI for 1986.

(b) Prohibit administration regulation on overpriced procedures and require study--In a Federal Register notice dated February 18, 1986, the Secretary announced a proposed rule that would authorize the Health Care Financing Administration to make payment reductions under part B on the basis of "inherent reasonableness." Under this regulation "new reasonable charge limits" could be established when the standard methodology results in "unreasonably excessive charges."

(c) Programs to increase physician participation--Each year physicians are given the opportunity to sign participation agreements. Carriers are required to administer the annual participating physician enrollment process, but do not otherwise conduct programs to encourage participation or to provide information to beneficiaries about the program. The Secretary of Health and Human Services is required to publish directories listing the name, address, and specialty of participating physicians. Directories are available for use by the public at district and branch offices of the Social Security Admininstration, and directories are sent to each participating physician to facilitate referrals between participating physicians.

(d) Unnecessary services--Carriers and peer review organizations (PROs) review the medical necessity of physician services provided to beneficiaries. Unnecessary services are not covered and payment is denied. By accepting assignment, physicians agree not to bill the beneficiary even if medicare payment is denied. If assignment is not accepted, physicians may bill for services which have been found to be medically unnecessary, and the beneficiary may be required to pay the physician's full charge even though no medicare reimbursement is allowed.

(e) Disclosure requirement--If assignment is accepted, the beneficiary is not liable for charges in excess of the medicare approved charge. There is no requirement that a physician inform a beneficiary of the estimated amount of the extra charges if assignment is not accepted.

Explanation of Provision.--(a) Extend and modify limits on physician fee increases-- On January 1, 1987, all physicians will receive an increase in prevailing charges based on percentage increase in the Medicare Economic Index (MEI) for services provided in 1987. The percentage increase in the MEI for 1987 is estimated to be 3.2%. The increase will apply to the maximum allowable prevailing charge levels for participating and nonparticipating physicians respectively as established by COBRA, and in effect during the 8-month period ending on December 31, 1986. In future years, the respective prevailing charge levels of participating and nonparticipating physicians will be increased by the percentage increase in the MEI applicable for services provided during the year. Participating physicians would receive an additional 1% bonus increase in their prevailing charges during 1987 and in each subsequent year. The bonus for a year will apply only to services provided during the year and will not apply in the calculation of payments for any subsequent year. In otherwords, the bonus will not be included in the prevailing charge profile and will not compound in future years.

Assuming a 3.2% MEI increase for 1987, a 3.0% increase for 1988, a 4% increase for 1989, for a $1000 maximum allowable prevailing charge for a participating physician during the 8-month period ending December 31, 1986, the maximum allowable prevailing charges in future years would be: $1042.00 in 1987 ($1000 x 1.042), $1073.28 in 1988 ($1000 x 1.032 x 1.04), and $1116.10 in 1989 ($1000 x 1.032 x 1.03 x 1.05). The maximum allowable prevailing charge for nonparticipating physicians in effect during the 8-month period ending on December 31, 1986 would be increased by 3.2% in 1987, 3.0% in 1988, and 4.0% in 1989.

The freeze on actual charges of nonparticipating physicians would be replaced by a limit on the rate of increase of actual charges, effective January 1, 1987. On that date, nonparticipating physicians could increase their actual charges by the 1987 MEI plus an additional 1%. In subsequent years, nonparticipating physicians could increase their charges by the MEI for the year. The additional 1% increase allowed in 1987 would be included in the base and would compound in future years.

Assuming a 3.2% MEI increase for 1987, a 3.0% increase for 1988, a 4% increase for 1989, for a $1000 actual charge for a nonparticipating physician during 1986, the physician could increase his actual charges in subsequent years to: $1042.00 in 1987 ($1000 x 1.042), $1073.26 in 1988 ($1042.00 x 1.03), and $1116.19 in 1989 ($1073.26 x 1.04).

A special limit on actual charges would apply to nonparticipating physicians without actual charge data for a procedure during the base period.

In this situation, nonparticipating physicians would be prohibited from charging more than the 50th percentile of customary charges (weighted by frequency) for the procedure as provided by nonparticipating physicians in the area during the 12-month period ending on June 30, 1986, increased by the percentage increase in the MEI since 1986.

Carriers would be required to provide available information concerning maximum allowed charges for nonparticipating physicians. Monitoring and enforcement procedures developed for the current freeze on actual charges would be continued. Nonparticipating physicians who knowingly and willfully bill more than the allowed amount would be subject to civil monetary penalties and/or exclusion from medicare.

The Secretary would be prohibited from adjusting the MEI on a retrospective basis by substituting a rental equivalence or rental substitution factor for the housing component of the consumer price index that had been used in determining the MEI prior to 1985. A retrospective adjustment of the MEI in this manner would have reduced the 1987 MEI by approximately 2 percentage points.

The Committee notes that the participating physician program is voluntary. The purpose of the program is to assist elderly who cannot afford to pay more than standard coinsurance and deductible payments. By selecting a participating physician, the beneficiary knows in advance that he or she will not be liable for any extra out-of-pocket costs. The Committee believes that elderly who cannot afford to pay extra should be provided an opportunity to select a physician who they know will always accept assignment. While the Committee is presently of the view that payment differentials are needed to encourage participation, the need for payment differentials may be reduced as the participation program becomes more fully established. In addition, the Committee believes that the need for payment differentials should be reconsidered in the context of forthcoming reforms in physician reimbursement.

(b) Prohibit administration regulation on overpriced procedures and require study--The Secretary and the Health Care Financing Administration would be prohibited from lowering medicare payment using either the "inherent reasonableness authority" or the proposed "new reasonable charge limitations" for services covered under medicare part B.

The Committee believes that the Secretary does not have the legislative authority to impose across-the-board cuts in payments. As provided by law, payment rates would continue to be determined on the basis of actual, customary, and prevailing charges and in certain cases the lowest charge level.

The provision prohibits actions by the Secretary to require carriers to reduce payment for items or services provided under part B where the proposed reduction in payment is based on a conclusion by the Secretary that charges for particular items or services are excessive. As provided in the Consolidated Omnibus Reconciliation Act of 1985, carriers would be permitted to correct for grossly excessive or grossly deficient charges, provided that the reasonable charge that is established is realistic and equitable. This carrier authority is limited to eliminating specific charges that are grossly excessive or deficient in comparison with charges for the same or similar items or services charged by other similarly situated vendors or suppliers. Such adjustments would be required to be made for particular items and services by carriers persuant to guidelines established by the Secretary in regulations published by the Secretary. The carriers may not use the "inherent reasonableness" authority to depart from the charge-based methodology mandated by law. The Committee intends simply to allow the carriers, in establishing the prevailing charge, to eliminate grossly deficient or grossly excessive charges for particular items and services; this authority may not be used to eliminate a significant proportion of charges which would, in effect, result in a substantial departure from the charge-based methodology mandated by law.

After consultation with the Physician Payment Review Commission, the Secretary would be required to submit a report to Congress concerning payment reductions for overpriced physician services. The report would list procedures determined to be overpriced and the recommended amount of payment reductions. The report would also describe proposals for implementing the payment reductions and measures to ensure that payment reductions do not result in increases in out-of-pocket costs for beneficiaries. The report would be due no later than April 1, 1987.

The provision is not intended to effect the validity or invalidity of the Secretary's regulation on inflation indexed charges for nonphysician services issued on September 30, 1985.

The Committee believes that certain physician services may be "overpriced" and that payment for these services should be reduced. The Committee is aware of a proposal being developed by the Administration to reduce payment for cataract surgery with intraoccular lens implantation. This proposal is based on a comparison of the amount of time required to perform cataract surgery with lens implantation to the amount of time required to perform the surgery without lens implantation. While the amount of the payment reduction that the Administration may propose may be reasonable, the Committee notes that the payment reductions likely to be proposed could result in an increase in extra charges on unassigned claims of as much as $500 per procedure. The Committee believes that such a result would be unacceptable. Accordingly, the Committee would prohibit payment reductions for "overpriced" procedures and require submission of recommendations by the Secretary concerning payment reductions and means to protect beneficiaries against increases in out-of-pocket costs.

(c) Programs to increase physician participation--During 1985, 31.4% of total charges for physicians' were made on an unassigned basis. The actual charge on unassigned claims were 26.9% higher than the medicare approved charge. Estimated beneficiary liability for extra charges on unassigned claims totalled $3.6 billion. A significant number of beneficiaries incurred extra charges on unassigned claims totalling more than $1,000 per beneficiary per year.

By selecting a participating physician, a beneficiary knows in advance that he/she will not be liable for any out-of-pocket costs other than standard coinsurance and deductable payments. Currently, about 28% of physicians participate.

To assist beneficiaries in selecting a participating physician and help them limit out-of-pocket costs, the Committee believes that a number of programs are warranted to strengthen the participating physician program.

A directory of participating physicians would be sent to each beneficiary at the beginning of each year starting in 1988. Directories would be organized to facilitate their use by beneficiaries. One or more directories would be used in each carrier service area as appropriate. Physicians would be listed by specialty and locality. The Committee believes that distribution of the directories is needed as a practical step to assist beneficiaries who wish to select a participating physician.

Carriers would be required to develop and implement programs to recruit and retain participating physicians. Recruitment programs would include: educational and outreach activities, seminars, and/or mail and telephone contacts, in addition to the basic annual mailing of participation letters. A professional relations staff for participating physicians would be required to handle billing and other problems related to payment of claims. Carriers would also be required to develop and implement programs to familiarize beneficiaries with the participating physician program and assist them in using the program to select physicians. The Secretary would be required to provide incentive payments to carriers that were successful in increasing the number of participating physcians. A bonus pool equal to 1% of total payments to carriers for claims processing would be available. Bonus payments would be made at the beginning of each year starting in 1988, based on the results of the participation enrollment process for the preceding year.

The medicare provider agreement for hospitals would be amended to require that hospitals make the participating physician directory available to beneficiaries. In addition, when referring a patient for further medical care on an outpatient basis, hospital personnel would be required to provide the name of at least one qualified participating physician of appropriate specialty if one is available.

(d) Unnecessary Services--The Committee believes that a consistent policy should apply with respect to liability for unnecessary services whether assignment is accepted or not. Under the provision adopted by the Committee, physicians who do not accept assignment on a claim would be prohibited from charging for unnecessary services. If payment has been made, the physician would be required to make a refund. A physician would be allowed to charge for a unnecessary service if: (i) the physician did not know and could not reasonably have been expected to know that the services would be determined to be unnecessary or (ii) the beneficiary was informed in advance that medicare coverage would be denied and agreed to pay for the service. Denial notices would be sent by the carrier (or the peer review organization) to both the physician and the beneficiary. Physicians would be required to refund payments within 30 days after receiving a denial notice unless the physician requests a reconsideration or appeal. The physician would be required to refund payment within 15 days after an adverse determination on reconsideration or appeal. A knowing and willful failure to make a refund on a timely basis would be subject to civil monetary penalties and/or exculsion from the medicare program.

(e) Disclosure requirement--The Committee believes that wherever practical, beneficiaries should be given information in advance concerning the amount of their potential liability for extra charges on unassigned claims. Without this information, beneficiaries cannot make informed decisions regarding source of care.

Under the provision adopted by the Committee, physicians providing elective surgical procedures on an unassigned basis would be required to provide fee information to the beneficiary in advance of performing the procedure. The physician would be required to provide a disclosure form that shows the physician's estimated actual charge for the procedure, the medicare approved charge, and the amount of any extra charges in excess of the medicare approved charge. The beneficiary would be required to sign the disclosure form, acknowledging receipt of this information. The requirement would only apply to elective surgical procedures as defined by the Secretary with an actual charge of $500 or more. Physicians failing to provide the disclosure would be required to refund any payments received from the beneficiary in excess of the medicare approved charge. Knowing and willful violations would be subject to civil monetary penalties and/or exclusion from the medicare program.

The Secretary would be required to develop an effective method for monitoring compliance with the requirement. One approach would be to modify the claim form to include a statement to be initialed by the beneficiary indicating that the required information had been provided. Carriers could initiate an investigation if the payment forms do not have the required initialling in a substantial number of procedures provided by a physician. Alternatively, a special notice could be provided in the explanation of medical benefits if the required initialling did not appear on the claim.

Effective Date.--Paragraph (a) is effective on January 1, 1987, except that the prohibition concerning retrospective adjustment of the MEI is effective on enactment. Paragraph (b) is effective on enactment. Paragraphs (c), (d), and (e) are effective on October 1, 1987.

3. Payment rates for renal services and improvements in administration of end stage renal disease networks and program (sec. 10233 of the bill)

Present law.--(a) Composite rates for dialysis treatment--End Stage Renal Disease (ESRD) facilities receive a "composite" payment rate for each dialysis treatment furnished. It is based on a weighted average of facility mix (hospital-based/free-standing) and a weighted average of in-facility and home dialysis. Free-standing facilites are currently paid on average $127 per treatment and hospital-based facilities receive on average $131 per treatment. Exceptions to the composite rate are provided if it is determined that a facility is an isolated essential facility. The Administration, in proposed regulations, is planning to reduce the composite payment rate for each treatment by approximately $11.00 (9%).

(b) Payment for physicians' services--Physicians are paid a monthly capitated payment for routine services provided to outpatient maintenance dialysis patients (ESRD). The rate of approximately $187 per patient per month is based on an assumption that the physician provides one brief visit per dialysis session and one intermediate visit per month to the average ESRD patient. The fee is adjusted for the proportion of home and facility patients treated. The Administration has issued a final notice, effective August 1, 1986, to reduce the monthly capitated payment by approximately $14 (8%).

(c) Reorganization of ESRD network areas and organizations--The Secretary is required to establish network organizations to assure effective and efficient administration of the ESRD program. The 32 network organizations are responsible for coordinating and evaluating ESRD services provided within assigned geographic areas. Under the Consolidated Omnibus Budget Reconciliation Act of 1986, the Secretary may consolidate the network areas to not less than fourteen. The Secretary is proposing through regulation to reduce the number of networks to 14 and modifying the functions of the networks.

Explanation of provision--(a) Composite rates for dialysis treatment--The facility composite rate would be reduced by approximately $5.50 per treatment (4.5%) based upon more recent cost audits, data on facility treatment mix, and home/in-facility dialysis mix. The base rate for free standing ESRD facilities could be no lower than $117.50 and for hospital based facilities, $121.50. This proposal overrides the Administration's proposed rule published in the Federal Register on May 13, 1986.

The Committee is concerned about the appropriateness of the Administration's proposed regulation to reduce the ESRD facility composite rate by approximately $11.00 per treatment. As a result, the General Accounting Office (GAO) was asked to critique the Administration's proposed reduction, considering the data and methodology used by HHS to compute the proposed rates. GAO responded in a report dated July 22, 1986, that the most recent data available to develop the proposed rates was used and used appropriately. GAO added that an exceptions process for facilities where the costs exceed the composite rate for reasons beyond their control would be appropriate.

Because of a concern that quality of care and access to care could be jeopardized by the $11.00 reduction in the composite rate proposed by the Administration, the Committee bill provides only half of the rate reduction proposed by the Administration. Further, the Committee is concerned about access to quality care in rural and isolated areas. The Committee expects HCFA to improve the exceptions process for facilities with costs higher than those reflected in the composite rate. Specifically, HCFA should define the term "isolated essential facility" to reduce the data requirements so that more facilities deserving an exception to the composite rate will be able to successfully apply for such status.

The Committee bill provides for the appeals process to be streamlined so that an exception would be deemed to be approved unless the Secretary disapproved it by not later than 45 working days from the date the application was filed with the intermediary. The Committee intends that the fiscal intermediaries will complete within 15 working days their recommendations so that HHS will have 30 working days to make its decisions. If the isolated essential facility status is granted the facility would receive reimbursement based upon its request from the date it filed for the exception.

(b) Payment for physicians' services--The monthly capitated payment (MCP) rate for physicians treating ESRD patients would be reduced by approximately $14 (8%) to reflect the shorter period of time spent on patients who receive their care at home. In 1983, the MCP rate was computed by HHS based on the average estimated physician involvement with ESRD patients, weighted by the national average percentage of patients who dialyze at home and at facilities. Generally, physicians have less involvement with home patients than with facility patients. GAO has determined that physicians could treat 3.9 home patients for every facility patient, a ratio of 3.9 to 1 rather than a 1.4 to 1 ratio used to established the 1983 rates. The Committee bill provides for the Secretary of HHS to provide for an adjustment in the home/facility physician treatment ratio (used in establishing such payment rates) from 1.4 to 1 in order to reduce by approximately $14 the average MCP rate for physician services to maintenance dialysis patients.

To better monitor the rate reductions, the Committee bill provides for the Secretary to contract with the National Academy of Science's Institute of Medicine to evaluate the effects of the proposed physician and facility rate reductions to determine if access to care or quality of care is being effected. A report to Congress on the results of the study is to be made by January 1, 1988. Once the study is completed it is the intent of the Committee to review the proposed rates.

(c) Reorganization of ESRD network areas and organizations--The Committee bill provides for a network program with a funding source that would better meet the needs of medicare ESRD beneficiaries. The bill would override the proposed rule published in the Federal Register on April 15, 1986.

The Secretary is directed to establish at least 17 ESRD networks. The Secretary is to publish in the Federal Register, after consultation with appropriate professional and patient organizations, the criteria for determining the geographic area for each network. In order to better evaluate the performance of networks in the future and to establish the reorganized networks, the Secretary is directed to establish standards, criteria and procedures for evaluating networks. The Committee intends that HHS will designate existing networks or a combination of existing networks in first establishing the new network organizations. The Committee hopes that existing networks will voluntarily combine and request being designated as the network in their geographic area. Once a network administrative organization agreement has been established it may not be terminated by the Secretary unless it fails to meet the established standards and criteria. At least one patient representative is to serve on each network council and medical review board.

The responsibilities of the networks are to include: (1)

collecting, validating and evaluating patient and facility data, (2) developing quality assurance standards, (3) conducting reviews and evaluations of the delivery of ESRD services, (4) conducting on-site review of the medical care provided beneficiaries in facilities when it is deemed necessary by a medical review board or the Secretary, (5) providing recommendations to ESRD facilities for improvements in ESRD care, (6) implementing a procedure for evaluating and resolving patient grievances, and (7) working with patients and facilities in encouraging participation in vocational rehabilitation programs.

In order for the networks to perform the functions required and to place the networks on a sound financial basis the Secretary would be required to reduce the amount of each composite rate payment for each treatment by 50 cents and provide for payment of such amounts to each network. Traditionally, home dialysis treatments are provided three times a week, thus $1.50 per week would be transferred to the area network. The Committee understands that some existing and emerging technologies may require the equivalent of more or less than three dialyses per week. It is the intent of this legislation that an ESRD patient be considered to have three dialyses per week and that $1.50 per week be transferred to the area network. Each network would receive the total amount withheld from facilities in that network's geographic area. If the new networks are not operational by January 1, 1987, it is the intent of the Committee that the Secretary is to fully fund the existing networks from this source of revenue.

The Secretary would be required to establish a national end stage renal disease registry from data reported by ESRD network organizations, transplant centers and other sources. This data should cover on all ESRD patients to assist the Congress and the medical community in dealing with ESRD related issues. The Secretary is to coordinate data collection activities and determine the appropriate location of the registry. A report on the progress made in establising the registry is due by January 1, 1987, and the registry is to be established by January 1, 1988.

Because of the controversy over the safety of reusing dialyzer filters, the Secretary would be required to establish by no later than January 1, 1988, protocols on standards and conditions for the reuse of dialyzer filters for those facilities and providers which reuse such filters. The Secretary is also directed to report by January 1, 1988, on the results of a study of the appropriateness of establishing protocols on standards and conditions for the reuse where appropriate of other dialysis supplies. The Secretary would be required to incorporate protocols established by this bill into the facilities' conditions of participation. Failure of a facility to follow an established protocol would subject the facility to denial of participation in the medicare program and to denial of payment for dialysis treatment.

Effective date.--The amendment applies to facility rates as of October 1, 1986, for physician rates August 1, 1986, for network organizations January 1, 1987.

4. Technical amendments and miscellaneous provisions related to part B (sec. 10234 of the bill)

Present Law.--(a) Additional members for Physician Payment Review Commission--The Physician Payment Review Commission as established by P.L. 99-272 consists of 11 commissioners. The purpose of the Commission is to provide recommendations concerning physician reimbursement under medicare part B.

(b) Effective date of voluntary disenrollment from medicare--Under current law, a beneficiary's coverage period under part B of medicare can be terminated by: (1) filing a notice that he or she no longer wishes to participate in the program; or (2) nonpayment of premiums.

When a beneficiary files a notice to disenroll from part B, the effective date of the termination is the close of the calendar quarter following the calendar quarter in which the notice is filed; a termination for nonpayment of premiums takes effect with the end of a grace period (not more than 90 days).

(c) Report on technical issues related to prospective payment of hospital-based physicians--Current law contains no provision.

Explanation of Provision.--(a) Additional members for Physician Payment Review Commission--The Commission would be expanded by two members. It is the Committee's intent that at least one of the new Commissioners be a rural physician.

(b) Effective date of voluntary disenrollment from medicare--The effective date of termination when filing a notice would be the close of the calendar quarter in which the notice is filed.

(c) Report on technical issues related to prospective payment of hospital-based physicians--The Secretary would be required to study and submit a report to the Committee on Ways and Means concerning technical issues related to design and implementation of a prospective payment system for hospital-based physicians.

The report would address the following issues: (i) definition of the specific radiology, antesthesia, and pathology services that could be included in a prospective payment system, (ii) the need, if any, for a transition from hospital-specific to national payment rates, (iii) methods available for adjusting payment rates to account for regional variations in practice costs or regional variation in general earnings levels, and (iv) other technical implementation problems. As part of the report, the Secretary would be required to develop a combined medicare part A and part B data file from the most recently available period for use in developing prospective payment rates for radiology, pathology, and anesthesia services (including services provided by certified registered nurse anesthetists) to beneficiaries who are hospital inpatients. The data file should consist of at least a 5% nationwide sample of all inpatient hospital admissions for medicare beneficiaries during a 6 to 12 month period of time. The data file should accumulate reasonable charges and costs for the listed services on a per-case (DRG) basis. The report and associated data files would be due as a report to the Committee on Ways and Means no later than April 1, 1987.

Effective Date.--Paragraph (a) would be effective 60 days after enactment. Paragraph (b) would be effective to notices filed on or after October 1, 1986. Paragraph (c) is effective on enactment.

Part 4 -- Improved Review of Quality by Peer Review Organizations

1. Improved Review of quality by Peer Review Organizations (sec. 10241 of the bill)

Present Law.--(a) PRO Review of Hospital Denial Notices--By regulation, hospitals are authorized to make determinations that further inpatient care is no longer medically necessary. If the attending physician concurs with this determination, the hospital may serve the beneficiary with a discharge notice and may begin to charge for continued stay beginning with the third day after serving the notice. The beneficiary may appeal the discharge notice to a peer review organization (PRO). If the PRO reverses the hospital's determination, the hospital may not bill for continued inpatient stay. The PRO is required to decide the appeal within three working days after receipt of the appeal. Under current policy, a beneficiary may incur financial liability for several days of continued stay before receiving notice of the PROs decision in the event of an adverse decision.

(b) PRO Review of Inpatient Services and Early Readmissions--PROs review the necessity and quality of hospital services provided to beneficiaries. To initiate review process, PROs must receive data concerning the number and type of hospital discharges from hospitals in the PROs service area. This information is provided to the PROs by the medicare fiscal intermediaries. There is no statutory provision regarding timely provision of data to the PROs. Under PRO contracts for 1986-88, PROs will be required to review all readmissions to a hospital where the readmission occurs within 15 days after initial discharge.

(c) Requiring PRO Review of Quality of Care--PROs are required to review a sample of the professional activities of health care practitioners and providers for purposes of determining whether the services provided were medically necessary and met professionally recognized standards of care. Under a provision of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, PROs are required to review services provided by health maintenance organizations (HMOs) and competitive medical plans (CMPs) effective January 1, 1987. The COBRA provision does not specify a required level of effort for PRO review of HMO and CMP services.

(d) Requiring Consumer Representation on PRO Boards--Current law contains no provision.

(e) Improving PRO Responsiveness to Beneficiary Complaints--Current law does not require that PROs review beneficiary complaints concerning quality.

(f) Sharing of Information by PROs--PRO confidential information is subject to rigorous protection. State ombudsmen and State protection and advocacy officials and national accreditation bodies, such as the Joint Commission on Accreditation for Hospitals, are not entitled to share PRO confidential information.

(g) PRO Funding--The costs of PRO review of inpatient hospital services is considered to be a cost incurred by hospitals in providing services to beneficiaries. Hospitals are required to have contracts with PROs under which PROs receive reimbursement for review costs by means of a direct transfer of funds by the Secretary from the Federal Hospital Insurance Trust Fund. Under current law, the aggregate amount to be paid to all PROs during a year must be no less than the aggregate amount expended during fiscal 1986 on PRO reviews adjusted for inflation.

Explanation of Provision.--(a) PRO Review of Hospital Denial Notices--The law would be amended to establish a statutory right to appeal a hospital discharge notice to a PRO and to ensure that a beneficiary who makes an appeal is not liable for continued stay until after receiving notice of the PROs decision. The beneficiary would have until noon on the next working day after receiving a discharge notice to file an appeal. The hospital would be required to transmit a copy of the medical records to the PRO prior to the close of business on the next working day after the day the beneficiary receives the discharge notice. The PRO would have one full working day after receiving the appeal and the records to decide the appeal and provide notice of its decision. The hospital would be prohibited from charging the beneficiary for continued stay until noon on the day after the beneficiary receives notice of the PROs decision.

The provision as adopted by the Committee does not require PROs to decide beneficiary appeals during weekends. If the number of appeals under this provision increases substantially, the Committee believes that may be appropriate to reconsider the matter and require that PROs consider beneficiary appeals during weekends.

(b) PRO Review of Inpatient Services and Early Readmissions--The Secretary of Health and Human Services would be required to ensure that PROs receive each month, on a timely basis, either directly from hospitals or indirectly through fiscal intermediaries, hospital data needed to initiate required reviews of hospital care on a timely basis. PROs would be required to review at least a sample of readmissions occurring within 31 days after the date of the most recent discharge from the hospital. It is the Committee's understanding that a large percentage sample of readmissions would be reviewed during the first two weeks after initial discharge than during the subsequent two week period.

(c) Requiring PRO Review of Quality of Care--Each PRO would be required to devote a reasonable proportion of its efforts to reviewing quality of care. Each PRO would also be required to provide a reasonable allocation of its quality of care review activities among the different settings in which services are provided to medicare beneficiaries. Factors to be considered in establishing a reasonable allocation of PRO review activities include the following -- (i) whether there is reason to believe that there is a particular need for reviews of particular cases or settings because of previous problems regarding quality of care; (ii) the cost of the reviews and the likely yield of reviews in terms of the number and seriousness of quality of care problems likely to be detected as a result of the review effort; and (iii) the availability and adequacy of alternative quality review and assurance mechanisms.

The Committee believes that it is important to remove any remaining uncertainty with respect to the requirement that PROs must review services provided by health maintenance organizations (HMOs) and competitive medical plans (CMPs). Under the provision approved by the Committee, PROs are required to initiate review of HMO and CMP services on January 1, 1987. The purpose of these reviews (which are to include both inpatient and outpatient services) is to determine whether the quality of care provided to beneficiaries meets professionally recognized standards of health care, including whether appropriate health care services have not been provided or have been provided in inappropriate settings. By January 1, 1988, the level of effort of PRO review for beneficiaries enrolled in HMOs and CMPs must be equivalent on a per beneficiary basis to the level of effort of PRO review (including both quality and utilization reviews) of services provided to beneficiaries who are not enrolled in HMOs or CMPs.

The Committee recognizes that HMOs and CMPs provide health care services in a manner that is distinctive. Accordingly, PRO review of HMO and CMP services should take into account unique characteristics of HMOs and CMPs. To ensure that PRO protocols for review of HMO and CMP services are appropriate, it is the Committee's intent that the standards, criteria, and procedures used for PRO review of HMO and CMP services be developed with the advice and consultation of representatives of the HMO and CMP industry. Representatives of PROs should also be involved in this consultative process.

(d) Requiring Consumer Representation on PRO Boards--Each peer review organization (PRO) would be required to name at least one consumer representative to its board of directors.

(e) Improving PRO Responsiveness to Beneficiary Complaints--PROs would be required to conduct a review of all written complaints about the quality of medicare covered services if the complaint is filed by a beneficiary or a legally responsible person acting on behalf of the beneficiary. The extent of the required investigation is to be determined on a case-by-case basis by the PRO depending on the circumstances. The PRO would be required to inform the complainant of its conclusions regarding the complaint and disposition of the complaint. Before concluding that the services involved fail to meet professionally recognized standards of care, the PRO would be required to provide notice and an opportunity for discussion with the practitioner or provider involved in the complaint.

(f) Sharing of Information by PROs--National accreditation bodies, such as the JCAH, acting pursuant to Section 1865 of the Social Security Act and State agencies responsible for licensing or certification of providers and practitioners would have access to confidential PRO information upon request if the information: (i) relates to a specific case or possible pattern of substandard care; and (ii) is needed for the body or agency to carry out its official function. State ombudsmen, and State protection and advocacy officials would have access to PRO confidential information upon request if the PRO determines that the information requested: (i) relates to quality of care; (ii) may reflect a failure in a substantial number of cases or a gross and flagrant failure in one or more instances to provide services of a quality which meets professionally recognized standards of care; and (iii) is needed by the body, ombudsman, or official to carrying out official duties.

(g) PRO Funding--The new PRO activities specified in this provision would be considered to be a cost incurred by providers (including HMOs and CMPs) providing covered services to beneficiaries and would be reimbursed in the aggregate by an amount not less than an amount determined by the Secretary to be sufficient to cover the costs of these activities. Funds identified under Section 1866(a)(1)(F)of the Social Security Act for PRO review of inpatient hospital services would continue to be used solely for the purpose inpatient hospital reviews by PROs and would not be used to cover the cost of the new PRO functions specified in this provision. Hospitals, SNFs, home health agencies, HMOs, and CMPs would be required to execute agreements with PROs regarding the review activities specified in this provision under which the activities would be considered to be a cost of providing services to be reimbursed by means of a direct transfer of funds from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund in appropriate amounts.

Effective Date.--Paragraph (a) would apply to hospital discharge notices served to beneficiaries starting with the first day of the first month that begins 30 days after enactment. The requirement under paragraph (b) concerning prompt submission of data would be effective no later than 6 months after enactment. The requirement under paragraph (b) concerning PRO review readmissions would be effective for PRO contracts entered into or renewed on or after January 1, 1987. The requirement under paragraph (c) concerning allocation of funds for PRO review is effective on January 1, 1987. The requirement of paragraph (c) concerning the level of effort of PRO review of HMOs and CMPs is effective on January 1, 1988. Paragraph (d) would apply to PRO contracts entered into or renewed on or after January 1, 1987. The requirement of paragraph (e) concerning review of beneficiary complaints amendment would apply to complaints received by PROs on or after the first day of the first month that begins 9 months after enactment. Paragraph (f) concerning PRO confidential information apply to requests for information received on or after the end of the first 6-month period after enactment. Paragraph (g) concerning PRO funding has an effective date of October 1, 1987 as it pertains to PRO review agreements with hospitals, SNFs, and health agencies and has an effective date of January 1, 1987 as it pertains to PRO review agreements with HMOs and CMPs.

Part 5 -- Assuring Access to Health Care

1. Incentives for the establishment of State health insurance pools (sec. 10251 of the bill)

Present law.--Under present law, states are not required to establish health insurance pools for the purpose of offering health insurance to people who are otherwise unable to purchase health insurance. Beginning in 1974 ten states have enacted laws establishing comprehensive health insurance pools. These states are: Rhode Island, Connecticut, Florida, Indiana, Minnesota, Montana, Nebraska, North Dakota, Wisconsin, and Tennessee. The state insurance pools are independent nonprofit corporations governed by a board and administered by an insurance carrier selected by the board.

Only health insurance carriers who provide health insurance plans which are governed by state law are required to participate in the pools. Because ERISA preempts state law, employer-based, self-funded health plans have been exempt from any state mandate.

Explanation of provision.--The Committee bill provides for each state to establish an insurance pool for people who do not have access to employment-based health insurance. Policies offered by the pools would have to be available to anyone in the state, expect for individuals eligible for part A of medicare, regardless of health status.

Once the state establishes a health insurance pool, any employer, with 20 or more employees, doing business in the state would be required to participate in the insurance pool. If the employer did not participate in the pool, a tax equal to 5% of gross wages (as defined in the Internal Revenue Code Sec. 3401) paid or incurred during the taxable year would be imposed. If a state does not create a pool, there would be no tax on employers.

The insurance policies offered under the state pool would be designed to offer coverage typical of large employer plans. A premium could be charged based upon the reasonable actuarial determination of anticipated experience and expected expenses. The premium rate would be expected to ensure that the pool is self-supporting, but in no event could it be higher than 150% of average premium rates for individual standard risks in the state for comparable coverage. To the extent the insurance pool is not self-supporting from premiums, losses would be made up by equitable assessments on all participating employers in the state.

The state insurance pool would not be permitted to establish a life-time limit on benefits of less than $500,000 and would have to cap annual out-of-pocket expenses for covered services at no more than $1,500 for individual coverage and $3,000 for family coverage. A choice of deductibles could be offered but could not exceed $1,000 for each covered individual.

Exclusions of coverage for preexisting conditions would be permitted but for no more than 6 months. Covered services offered under the plan would be required to include the purchase and repair of medically necessary durable medical equipment.

The Committee realizes that the state health insurance pools defined under this provision are generally designed for people who can afford to pay the premiums. A state or other entity would be permitted to provide payment of part or all of the premium of an enrollee and could vary the amount of the payment based on the enrollee's income or on some other basis.

Based upon testimony, pool losses ranged from $0.50 to $1.40 per person covered by health insurance in the states having pools in place. The Committee therefore believes, based on the experience of the states which have enacted similar legislation, that the general losses will be small.

The Committee anticipates that the establishment of these health insurance pools will take some pressure off the need for new or existing public programs for people who do not have access to health insurance.

The Committee bill intends that each State should establish a pool by not later than January 1, 1988, or if later, the end of the first regular State legislative session that begins after the date of enactment of this Act.

Effective date.--The proposal would be effective for taxable years beginning on or after January 1, 1988.

2. COBRA technical amendments relating to continuation of employer-based health insurance coverage (sec. 10252 of the bill)

Present law.--Section 10001 of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) amended the Internal Revenue Code to require that group health plans of covered employers provide qualified beneficiaries the opportunity to continue health care coverage under the plan if they paid up to 102% of the applicable premium in certain instances where coverage under the employer-based health plan would otherwise be terminated. The continuation coverage amendments apply to plan years beginning on or after July 1, 1986. In the case of collectively bargained plans, the amendments do not apply to plan years beginning before the later of (1) the date on which the last collective bargaining agreement relating to the plan terminates, or (2) January 1, 1987.

(a) Modification of coverage--Under current law the coverage must consist of coverage which is identical to the coverage provided under the plan to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred.

(b) Maximum period of continuation coverage--Under current law the maximum period of continuation coverage relating to terminations and reduced hours is 18 months and for divorced, legally separated, medicare ineligible spouses and their dependents and dependents who lose their dependent status under the plan 36 months. No provision was made for multiple qualifying events. These time periods are the general rule unless the employer ceases to provide any group health plan to any employee, the qualified beneficiary fails to pay the premium in a timely manner or becomes a covered employee under any other group health plan, or becomes entitled to medicare, or remarries and is covered under another group health plan.

(c) Grace period for payment of premiums--Under current law coverage ceases under the plan by reason of a failure to make timely payment of any premium required under the plan with respect to the qualified beneficiary. No specific time period is specified.

(d) Election of beneficiaries--Under current law each qualified beneficiary is entitled to a separate election but a spouse of a covered employee or a covered employee can elect coverage on behalf of any other qualified beneficiary in the family who would lose coverage under the plan by reason of the qualifying event.

(e) Notice requirement--Under current law the employer of an employee under a plan must notify the plan administrator within thirty days of a qualifying event if the qualifying event is the death of the employee, the termination (other than by reason of such employee's gross misconduct), or reduction of hours of the covered employee's employment, or if the covered employee becomes entitled to medicare. Divorced or legally separated spouses and dependent children ceasing to be dependents under the plan are required to notify the plan administrator of the occurrence of such events but no time limit was established for notifying the plan administrator.

Explanation of provision.--(a)Modification of coverage--The general rule is that in all respects qualified beneficiaries are to be treated under the plan as similarly situated beneficiaries for whom a qualifying event has not taken place. For example, if the plan provides for an open enrollment period then qualified beneficiaries must be able to elect in the same manner as active employees. This means that a qualified beneficiary by reason of being a spouse of a covered employee would have the same rights as active employees during an open enrollment period and would not be limited to the rights of spouses of covered employees. By health benefits, the Committee means to include health benefit plans that include dental and vision care as defined in Sec. 213 of the Internal Revenue Code. This does not mean that an employer could compel the qualified beneficiary to pay for non-core benefits even if active employees have to accept core and non-core services under the plan.

(b) Maximum period of continuation coverage--The bill clarifies that a qualified beneficiary may have more than one qualifying event which entitles the beneficiary to continuation coverage but in no case may the coverage period with respect to such events (other than the period applicable to a qualifying event described in paragraph (3) (F)of the law) exceed a 36-month period. For example, a qualified beneficiary retires and then dies or is divorced, the qualified beneficiary spouse then has a second qualifying event which entitles this spouse to a total of 36 months of continuation coverage. However, the second qualifying event must take place during the period of coverage of the first qualifying event to be eligible for a total of 36 months from the date of the first qualifying event.

(c) Grace period for payment of premiums--The bill clarifies that the grace period is the longer of three periods: 30 days, the period the plan allows employees, or the period the insurance company allows the plan or employer whichever the case may be.

(d) Election by beneficiaries--The Committee bill clarifies that each qualified beneficiary is entitled to a separate election. The Committee realizes that normally an employed worker will elect coverage for the entire family. If the covered employee does not elect continuation coverage, however, the spouse and or dependent children are entitled to elect coverage. Moreover, even if the employee elects certain coverage, the spouse and or dependents may elect different coverage.

(e) Notice requirement--The Committee bill establishes a 60-day notification period for divorced or legally separated spouses of covered employees or dependent children ceasing to be dependent children under the generally applicable requirements of the plan, to notify the plan administrator of such qualifying events.

Effective date.--The amendments made by these provisions are effective as if they had been included in the enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985.

3. Continuation coverage for retirees in cases of bankruptcies (sec. 10253 of the bill)

Present law.--Section 10001 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) entitles employees covered under the employer's health plan who terminate employment up to 18 months of continuation coverage under the employer plan if they pay up to 102% of the applicable premium. However, this provision is only effective for an employer health plan year that begins on or after July 1, 1986. A special rule is provided for collectively bargained plans. Current law makes no provision for retirees who retire before the employer's new health plan year begins on or after July 1, 1986. Current law also does not include as a qualifying event, for purposes of triggering the continuation option, an employer filing for Title 11 bankruptcy proceedings.

Explanation of provision.--The bill would amend section 10001 of COBRA to include a new qualifying event, a new class of qualified beneficiaries and a new period of coverage for certain retirees, their spouses and dependent children and widows. Specifically, the legislation would define as a qualifying event, with respect to the employer from whose employment the covered employee retired at any time, the filing of a proceeding in a case under Title 11, U.S. Code, commencing on or after July 1, 1986. In order to be considered a qualifying event, the proceeding would have to result in a substantial elimination of coverage for the qualified beneficiary as defined below.

In the case of such a qualifying event a loss of coverage includes a substantial elimination of coverage with respect to a qualified beneficiary, as described below, within one year before or after the date of commencement of the Title 11 proceeding. For example, an employer contemplating filing for Title 11 bankruptcy proceedings may not in the year before or after filing for Title 11, reduce the health insurance coverage so that it offers minimal coverage. Such a reduction in health insurance coverage for retirees, their spouses and dependent children and widows, would trigger the continuation coverage provision included in this legislation.

The Committee is concerned that retirees who retire before the COBRA provision becomes effective for the employer's plan year beginning on or after July 1, 1986, might lose their employer-based health insurance, if the employer filed for Title 11 bankruptcy proceedings.

In the case of a qualifying event resulting from an employer filing for Title 11 bankruptcy proceedings, a qualified beneficiary would be defined as including a covered employee who retired on or before the date of substantial elimination of coverage and any other individual who, on the day before the qualifying event, is a beneficiary under the plan: (1) as the spouse of the covered employee, (2) as the dependent child of the covered employee, or (3) as the surviving spouse of the covered employee. The term covered employee means an individual who is (or was) provided coverage under a group health plan by virtue of the individual's employment or previous employment with an employer. This means that the definition of covered employee includes an individual who has retired from employment from the employer and is receiving health benefits from that employer.

A qualified beneficiary who had retired on or before July 1, 1986, as described in the above paragraph, the spouse and dependent children and the widow of such a retired qualified beneficiary who were also qualified beneficiaries under the plan on the day before the qualifying event are entitled to elect to continue in the employer-based health insurance plan until the death of the covered employee. A surviving spouse who was a qualified beneficiary under the plan on the day before the qualifying event is entitled to elect continuation coverage until death. However, after the date of the death of the covered employee a new qualifying event is triggered which would entitle the surviving spouse and dependent children who are qualified beneficiaries of the covered employee to elect 36 months of continuation coverage.

As defined in section 10001 of COBRA, coverage ceases on: (1) the date on which the employer ceases to provide any group health plan to any employee, (2) failure to make timely payment of any premium required under the plan with respect to the qualified beneficiary, (3) reemployment resulting in a covered employee being covered under any other group health plan or (4) remarriage resulting in coverage under a group health plan. However, entitlement to medicare coverage does not terminate coverage with respect to qualified beneficiaries in the case of a qualifying event resulting from an employer filing for Title 11 bankruptcy proceedings. It is the intent of this provision to override the general effective date of section 10001 of COBRA and the collective bargaining agreement effective date of COBRA.

Notwithstanding this legislation, the Committee understands the contractual obligation of some employers that have filed for Title 11 bankruptcy is very clear and that they cannot divest themselves of the obligation to provide retiree health insurance. The Committee bill includes this provision because the contractual obligation may not be as clear in other cases. By including this provision in the bill the Committee does not intend to express any opinion as to the additional rights or obligations that may exist under collective bargaining agreements or any other Federal or state law.

Effective date.--In general this legislation takes effect as if included in section 10001 of COBRA. However, the legislation shall apply in the case of plan years ending during the twelve month period beginning July 1, 1986, in the case of a qualifying event resulting from an employer filing for Title 11 bankruptcy proceedings as defined above or relating to the death of the covered employee occurring after July 1, 1986. A special transition rule applies to covered employees who have died after July 1, 1986.

Subtitle D. -- Revenue Provisions

1. Extension of telephone excise tax (secs. 10301 and 10302 of the bill)

Present law.--A three-percent excise tax is imposed on amounts paid for local telephone service, toll telepone service, and teletypewriter exchange service (Code sec. 4251). The tax is paid by the service-recipient to the person rendering the service; the service-provider in turn remits the tax to the Federal Government.

Exemptions from the tax are provided for communications services furnished to news services (except local telephone service to news services), international organizations, the American National Red Cross, servicemen in combat zones, nonprofit hospitals and educational organizations, and State and local governments. Other exemptions are provided for amounts paid for installation charges and for certain calls from coin-operated telephones (sec. 4253). The tax does not apply to private communications systems (sec. 4252(d)).

Under present law, this excise tax is scheduled to terminate, effective with respect to amounts paid pursuant to bills first rendered after December 31, 1987.

Explanation of provision.--The bill extends the telephone excise tax at a three-percent rate for two years, through December 31, 1989.

The bill further requires the Treasury Department to study the possible effects of this tax in encouraging businesses to create their own, private telecommunications systems, bypassing regulated commercial carriers. This study is to consider the loss of excise tax receipts as a result of such systems and the appropriateness of continuing the present-law exemptions for private communications services and for other specified purposes or entities. The study is to be submitted to the Committee on Ways and Means and the Committee on Finance before January 1, 1988.

Effective date.--This provision is effective on the date of enactment.

III. Cost Estimates

A. Committee Estimate

Table 1 below summarizes the budget effects of the spending and tax provisions of the Committee's recommendation under the same economic and baseline assumptions used in the fiscal year 1987 budget resolution. These estimates are identical to those made by the Congressional Budget Office and the Joint Committee on Taxation. The budget effect includes all impacts the provision may have on other programs. For example, many of the Medicare and AFDC provisions have impacts upon the Medicaid program.

Aggregate savings over the 3-year period from fiscal 1987 to 1989 of the Committee's recommendations are in excess of the reconciliation instruction given to the Committee in the fiscal year 1987 budget resolution. The budget resolution assumed additional spending because it assumed the Committee would lower the inpatient hospital deductible. Thus, as shown in Table 1, net deficit reduction assumed by the resolution was $11.6 billion. Total net deficit reduction achieved by the Committee's recommendations over the three-year period from fiscal year 1987 to 1989 is $12.0 billion, some $.4 billion above the savings assumed in the resolution.

Table 1. Outlay and Revenue Provisions As Recommended by the Committee on Ways and Means Related to the Requirements of the Fiscal Year 1987 Budget Resolution

	(Savings, in millions)			
	FY87	FY88	FY89	3-year Total
A. Budget Resolution Targets				
Reconciliation Instruction	$4,350	$4,095	$4,190	$12,635
Allowed Spending	(250)	(400)	(350)	(1,000)
Net Deficit Reduction	4,100	3,695	3,840	11,635
B. Committee Recommendations				
Social Security				
Remove COLA Trigger	--	--	--	--
Accelerate state & local deposit of payroll taxes	394	294	1,158	1,846
Public Assistance				
AFDC-UP	0	(115)	(255)	(370)
FY 1987 Federal AFDC Percentage	(15)	--	--	(15)
IEVS Targeting	--	--	--	--
FUTA Repayment Tax Extension	0	903	1,247	2,150
Medicare				
Set Hospital Deductible at $500 in 1987	(580)	(230)	--	(810)
Hospital payment increases of 1.3 for FY 87 and Market Basket Minus 2.0% for FY 88	250	1,100	1,320	2,670
Limit Aggregate Capital Payment Increases to 10% Annually	155	355	590	1,100
Include Puerto Rico into PPS System	(10)	(15)	(20)	(45)
Quality Protections	(74)	(95)	(193)	(362)
Medicare Off-budget in 1987	--	--	--	--
Eliminate Periodic Interim Payments with Prompt Pay for Providers	1,970	(480)	130	1,620
HMO Amendments	--	--	--	--
Eliminate HMO 2-for-1 Rule	(25)	(50)	(45)	(120)
Extend Part B 25% Premium Policy for One Year	0	0	440	440
Extend and Modify Limits on Physician Fee Increase	(55)	(45)	50	(50)
Programs to Increase Physician Participation*		(100)	(100)	(200)
Disallow Administrative Regulation on Overpriced Procedures and Require Study	--	--	--	--
Reduce Rates to ESRD Facilities and Physicians and Strengthen Networks	92	100	105	297
Technical Amendments and Miscellaneous Provisions	--	--	--	--
High Risk Health Insurance Pools	--	--	--	--
COBRA Health Insurance Amendments	--	--	--	--
Revenues				
Extend Telephone Excise Tax for 2 Years	0	1,337	2,290	3,627
TOTAL (Net Deficit Reductions)	2,102	3,059	6,817	11,978

NOTE: Numbers in parenthesis indicate the provision will cost not save money.

* Not included in totals. Dollar amounts determined by appropriation action.

B. CBO estimates

CONGRESSIONAL BUDGET OFFICE
U.S. CONGRESS
WASHINGTON, D.C. 20515

Rudolph G. Penner
Director

July 28, 1986

Honorable Dan Rostenkowski
Chairman
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

The Congressional Budget Office has prepared the attached cost estimates of the provisions in the House Committee on Ways and Means reconciliation package. Provisions with no outlay or revenue effect are not listed in the tables. The estimates are shown in two separate attachments--one showing estimated outlay effects and one showing estimated revenue effects.

If you wish further details on this estimate, we will be pleased to provide them.

With best wishes,

Sincerely,

Rudy Penner

Rudolph G. Penner

cc: Honorable John J. Duncan
Ranking Minority Member

TABLE 1. THE ESTIMATED REVENUE EFFECTS OF THE COMMITTEE ON WAYS AND MEANS RECONCILIATION PROVISIONS RELATIVE TO THE BUDGET RESOLUTION BASE (Fiscal years, in billions of dollars)

	1987	1988	1989	3-Year Total
Extend telephone excise tax for two years, net	--	1.337	2.290	3.627
Extend FUTA repayment tax for two years	--	.903	1.247	2.150
Accelerate state and local Social Security deposits	.394	.294	1.158	1.846
Eliminate 3 percent trigger for cost-of-living increases	0.000	0.000	0.000	0.000
Total Revenue Effect, Net	**.394**	**2.534**	**4.695**	**7.623**

28-Jul

Table 2. ESTIMATED OUTLAY EFFECTS OF THE COMMITTEE ON WAYS AND MEANS RECONCILIATION BILL RELATIVE TO THE BUDGET RESOLUTION BASELINE
(By fiscal year, in millions of dollars)

PROVISIONS		1987	1988	1989	3-Year Total
Subtitle A--OASDI Provisions					
Direct Spending					
Eliminate trigger for COLAs		No change relative to CBO baseline that assumes the payment of a 3.4% COLA.			
Subtitle B--Provisions Relating to Public Assistance and Unemployment Taxes					
Direct Spending					
Mandate AFDC	BA	0	115	255	370
	O	0	115	255	370
Hold harmless 1987 change in Federal match rate	BA	15	0	0	15
	O	15	0	0	15
Amend Income Verification	BA	*	*	*	*
	O	*	*	*	*
Subtitle C--Medicare and Health Programs (Part A of Medicare would be off-budget as a result of this legislation)					
Direct Spending					
PART 1--PROVISIONS RELATING TO MEDICARE PART A ONLY					
Limit 87 deductible to $500	BA	-60	-85	-90	-235
	O	580	230	0	810
Limit Hospital increase (1.3% in 87, mb-2 in 88)	BA	10	80	195	285
	O	-250	-1100	-1320	-2670
Limit capital-- 86 plus 10%, 20%, and 30% PPS facilities only	BA	10	35	80	125
	O	-155	-355	-590	-1100
Puerto Rico	BA	0	-5	-5	-10
	O	10	15	20	45
Quality Bill- Part A	BA	-5	-10	-20	-35
	O	58	70	167	295

page 2 PROVISIONS		1987	1988	1989	3-Year Total
-PART 2--PROVISIONS RELATING TO MEDICARE PARTS A AND B					
PIP/prompt pay	BA	95	920	320	1335
	O	-1970	480	-130	-1620
HMO 2 for 1 rule	BA	30	55	45	130
	O	25	50	45	120
Quality Bill	BA	2	1	1	4
	O	6	8	8	22
PART 3--PROVISIONS RELATING TO MEDICARE PART B					
Part B premiums set at 25% in 1989	BA	0	0	-440	-440
	O	0	0	-440	-440
Physician increase, non-par 3.2% and pars at 4.2%	BA	50	30	-70	10
	O	55	45	-50	50
ESRD	BA	-98	-103	-108	-309
	O	-92	-100	-105	-297
PART 4--IMPROVED REVIEW OF QUALITY BY PROs					
Improved review by PROs	BA	3	4	4	11
	O	10	17	18	45
PART 5--Assuring Access to Health Care					
Continue covering retirees in cases of bankruptcies	BA	*	*	*	*
	O	*	*	*	*
AUTHORIZATION					
PART 3--PROVISIONS RELATING TO MEDICARE PART B					
Physician participation	O	0	100	100	200
TOTAL-DIRECT SPENDING (on and off budget)	BA	52	1037	167	1256
	O	-1708	-525	-2122	-4355
TOTAL-AUTHORIZATIONS	O	0	100	100	200

This table summarizes the bill's estimated impact on the federal budget, relative to both current law and budget resolution baseline, as adjusted for enacted legislation. The House Budget Committee has specified that reconciliation savings are to be measured from the baseline used by the budget conferees adjusted for subsequently enacted legislation.

* Less than $500,000

TITLE X--HOUSE COMMITTEE ON WAYS AND MEANS

Subtitle A--OASDI Provisions
Subtitle B--Provisions Relating to Public
Assistance and Unemployment Taxes
Subtitle C--Provisions Relating to Medicare
Subtitle D--Revenue Provisions

Subtitle A--OASDI Provisions

SEC. 10001. ELIMINATION OF 3-PERCENT TRIGGER FOR COST-OF-LIVING INCREASES.

(a) ELIMINATION OF TRIGGER.--Section 215(i)(1)(B) of the Social Security Act is amended by striking out ``with respect to which the applicable increase percentage is 3 percent or more'' and inserting in lieu thereof ``with respect to which the applicable increase percentage is greater than zero''.

(b) CONFORMING AMENDMENTS.--

(1) IN CURRENT LAW.--Section 215(i) of such Act is further amended--

(A)(i) by striking out clause (i) in paragraph (2)(C) and redesignating clauses (ii) and (iii) of such paragraph as clauses (i) and (ii), respectively, and

(ii) by striking out ``under clause (ii)'' in clause (ii) of such paragraph as so redesignated and inserting in lieu thereof ``under clause (i)'';

(B) by inserting ``and by section 10001 of the Omnibus Budget Reconciliation Act of 1986'' after ``Social Security Amendments of 1983'' in paragraph (4); and

(C) by striking out ``because the wage increase percentage was less than 3 percent'' in paragraph (5)(A)(i) and inserting in lieu thereof ``because there was no wage increase percentage greater than zero''.

(2) IN APPLICABLE FORMER LAW.--Section 215(i) of such Act, as in effect in December 1978 and applied in certain cases under the provisions of such Act in effect after December 1978, is amended--

(A) by striking out ``, by not less than 3 per centum,'' in paragraph (1)(B); and

(B)(i) by striking out clause (i) of paragraph (2)(C) and redesignating clauses (ii) and (iii) of such paragraph as clauses (i) and (ii), respectively, and

(ii) by striking out ``under clause (ii)'' in clause (ii) of such paragraph as so redesignated and inserting in lieu thereof ``under clause (i)''.

(c) TECHNICAL AMENDMENT TO SMI PROGRAM.--Section 1839(f)(2)(A) of such Act is amended to read as follows:

(A) the monthly premium amount determined under subsection (a)(2) for that January reduced by the amount (if any) by which the monthly benefit under section 202 or 223 for that November, after the deduction of the premium (disregarding subsection (b)) for that individual for that December and after rounding under section 215(g), would exceed the monthly benefit under section 202 or 223 for that December, after the deduction of the monthly premium amount determined under subsection (a)(2) (disregarding subsection (b)) for that individual for that January and after rounding under section 215(g), or''.

(d) EFFECTIVE DATE.--(1) Except as provided in paragraphs (2) and (3), the amendments made by this section shall apply with respect to cost-of-living increases determined under section 215(i) of the Social Security Act (as currently in effect, and as in effect in December 1978 and applied in certain cases under the provisions of such Act in effect after December 1978) in 1986 and subsequent years.

(2) The amendments made by paragraphs (1)(A) and (2)(B) of subsection (b) shall apply with respect to months after September 1986.

(3) The amendment made by subsection (c) shall apply with respect to monthly premiums (under section 1839 of the Social Security Act) for months after December 1986.

SEC. 10002. DEPOSITS OF SOCIAL SECURITY CONTRIBUTIONS BY STATE AND LOCAL GOVERNMENT EMPLOYERS.

(a) RETURNS AND PAYMENTS.--(1) Subchapter C of chapter 21 of the Internal Revenue Code of 1954 is amended by redesignating section 3126 as section 3127, and by inserting after section 3125 the following new section:

``**SEC. 3126. RETURN AND PAYMENT BY GOVERNMENTAL EMPLOYER.**

``If the employer is a State or political subdivision thereof, or an agency or instrumentality of any one or more of the foregoing, the return of the amount deducted and withheld upon any wages under section 3101 and the amount of the tax imposed by section 3111 may be made by any officer or employee of such State or political subdivision or such agency or instrumentality, as the case may be, having control of the payment of such wages, or appropriately designated for that purpose.''.

(2) The table of sections for subchapter C of chapter 21 of such Code is amended by striking out the last item and inserting in lieu thereof the following:

``Sec. 3126. Return and payment by governmental employer.
``Sec. 3127. Short title.''.

(b) TREATMENT OF SERVICE UNDER SECTION 218 AGREEMENTS AS EMPLOYMENT PERFORMED BY EMPLOYEES.--

(1) SERVICE TREATED AS EMPLOYMENT.--(A) Section 3121(b)(7) of such Code is amended--

(i) by striking out ``; or'' at the end of subparagraph (C) and inserting in lieu thereof a comma;

(ii) by striking out the semicolon at the end of subparagraph (D) and inserting in lieu thereof ``, or'', and

(iii) by adding after subparagraph (D) the following new subparagraph:

``(E) service included under an agreement entered into pursuant to section 218 of the Social Security Act;''.

(B) Section 1402(b) of such Code is amended by striking out ``under an agreement entered into pursuant to the provisions of section 218 of the Social Security Act (relating to coverage of State employees), or'' in the flush sentence immediately following paragraph (2).

(2) INDIVIDUAL PERFORMING SERVICES TREATED AS EMPLOYEE.--(A) Section 3121(d) of such Code is amended by redesignating paragraph (3) as paragraph (4), and by inserting after paragraph (2) the following new paragraph:

``(3) any individual who performs services that are included under an agreement entered into pursuant to section 218 of the Social Security Act; or''.

(B) Section 3306(i) of such Code is amended by striking out ``subparagraphs (B) and (C) of paragraph (3)'' and inserting in lieu thereof ``paragraph (3) and subparagraphs (B) and (C) of paragraph (4)''.

(c) CONFORMING AMENDMENTS IN SOCIAL SECURITY ACT.--(1) Subsections (e), (h), (i), (j), (q), (r), (s), and (t) of section 218 of the Social Security Act are repealed; and subsections (f), (g), (k), (l), (m), (n), (o), (p), and (u) of such section are redesignated as subsections (e), (f), (g), (h), (i), (j), (k), (l), and (m), respectively.

(2)(A) Section 205(c)(1)(D)(i) of such Act is amended by inserting ``(as in effect prior to December 31, 1986)'' after ``section 218(e)''.

(B) Section 205(c)(5)(F)(iii) of such Act is amended--

(i) by inserting ``(as in effect prior to December 31, 1986)'' after ``section 218'', and

(ii) by inserting ``(as so in effect)'' after ``subsection (q) of such section''.

(C) Section 218(d)(6) of such Act is amended--

(i) by striking out ``subsection (f)'' in subparagraph (A) and inserting in lieu thereof ``subsection (e)'', and

(ii) by striking out ``subsection (f)(1)'' in subparagraph (F) and inserting in lieu thereof ``subsection (e)(1)''.

(D) Section 218(d)(8)(D) of such Act is amended by striking out ``subsection (p)'' and inserting in lieu thereof ``subsection (l)''.

(E) Section 218(e)(1) of such Act (as redesignated by paragraph (1) of this subsection) is amended by striking out ``Except as provided in subsection (e)(2), any agreement'' and inserting in lieu thereof ``Any agreement''.

(F) Section 224(a)(2)(B) of such Act is amended by striking out ``section 218(k)'' and inserting in lieu thereof ``section 218(g)''.

(d) EFFECTIVE DATE.--The amendments made by this section are effective with respect to payments due with respect to wages paid after December 31, 1986, including wages paid after such date by a State (or political subdivision thereof) that modified its agreement pursuant to the provisions of section 218(e)(2) of the Social Security Act prior to the date of the enactment of this Act; except that in cases where, in accordance with the currently applicable schedule, deposits of taxes due under an agreement entered into pursuant to section 218 of the Social Security Act would be required within 3 days after the close of an eighth-monthly period, such 3-day requirement shall be changed to a 7-day requirement for wages paid prior to October 1, 1987, and to a 5-day requirement for wages paid after September 30, 1987, and prior to October 1, 1988. For wages paid prior to October 1, 1988, the deposit schedule for taxes imposed under sections 3101 and 3111 shall be determined separately from the deposit schedule for taxes withheld under section 3402 if the taxes imposed under sections 3101 and 3111 are due with respect to service included under an agreement entered into pursuant to section 218 of the Social Security Act.

Subtitle B--Provisions Relating to Public Assistance and Unemployment Taxes

SEC. 10101. MANDATORY PROVISION OF AID WITH RESPECT TO DEPENDENT CHILDREN IN TWO-PARENT FAMILIES.

(a) REQUIREMENT THAT AID BE PROVIDED.--Section 402(a) of the Social Security Act is amended--

(1) by striking out ``and'' after the semicolon at the end of paragraph (38);

(2) by striking out the period at the end of paragraph (39) and inserting in lieu thereof ``; and''; and

(3) by inserting immediately after paragraph (39) the following new paragraph:

``(40) provide that payments of aid will be made under the plan with respect to dependent children of unemployed parents, in accordance with section 407.''.

(b) CONFORMING AMENDMENTS.--(1) Section 407(b) of such Act is amended by striking out ``(b) The provisions'' and all that follows down through ``(1) requires'' and inserting in lieu thereof the following:

``(b) In providing for the payment of aid under the State's plan approved under section 402 in the case of families which include dependent children within the meaning of subsection (a) of this section, as required by section 402(a)(40), the State's plan--

``(1) shall require''.

(2) Section 407(b)(2) of such Act is amended by striking out ``provides--'' and inserting in lieu thereof ``shall provide--''.

(c) QUARTERS OF WORK BASED ON EDUCATION OR TRAINING.--(1) Section 407(d)(1) of such Act is amended--

(A) by inserting ``(A)'' after ``means a calendar quarter''; and

(B) by inserting before the semicolon at the end thereof the following: ``, or (B) if the State plan so provides (but subject to the last sentence of this subsection), in which such individual (i) was in regular full-time attendance as a student at an elementary or secondary school, (ii) was in regular full-time attendance in a course of vocational or technical training designed to fit him or her for gainful employment, or (iii) participated in an education or training program established under the Job Training Partnership Act''.

(2) Section 407(d) of such Act is further amended by adding at the end thereof (after and below paragraph (4)) the following new sentence:

``No individual shall be credited during his or her lifetime (for purposes of subsection (b)(1)(C)(i)) with more than 4 `quarters of work' based on attendance in a course or courses of vocational or technical training as described in paragraph (1)(B)(ii) of this subsection.''.

(3) Section 407(b)(1)(C)(i) of such Act is amended by inserting after ``6 or more quarters of work (as defined in subsection (d)(1))'' the following: ``, including 2 or more quarters of work as defined in subsection (d)(1)(A),''.

(d) EFFECTIVE DATE.--The amendments made by this section shall become effective January 1, 1988.

SEC. 10102. TARGETING UNDER INCOME AND ELIGIBILITY VERIFICATION SYSTEM.

Section 1137(a)(4)(C) of the Social Security Act is amended by inserting after ``payments'' the following: ``, and no State shall be required to use such information to verify the eligibility of all recipients''.

SEC. 10103. ANNUAL CALCULATION OF FEDERAL PERCENTAGE FOR AFDC PURPOSES.

Section 9528(c) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (as added by section 4621(a) of this Act) is amended (effective as provided in section 4621(b))--

(1) by striking out ``payment to a State under section 1903'' and inserting in lieu thereof ``payments to States under sections 403 and 1903''; and

(2) by inserting ``with respect to either such section'' after ``shall not apply to a State''.

SEC. 10104. RATE OF FUTA TAX.

(a) IN GENERAL.--Paragraph (1) of section 3301 of the Federal Unemployment Tax Act is amended by striking out ``1976'' and inserting in lieu thereof ``1989''.

(b) EFFECTIVE DATE.--The amendment made by this section shall apply to remuneration paid after December 31, 1986.

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PART 1--PROVISIONS RELATING TO MEDICARE PART A ONLY

SEC. 10201. SETTING PART A DEDUCTIBLE AT $500 FOR 1987.

For purposes of part A of title XVIII of the Social Security Act, and notwithstanding any provision of such part to the contrary, the inpatient hospital deductible (otherwise determined under section 1813(b) of such Act) for 1987 shall be $500. Such amount shall be applied--

(1) to inpatient hospital services furnished in 1987,

(2) in computing, under section 1813(b)(3) of such Act, the coinsurance amount for post-hospital expended care services furnished in 1987, and

(3) in computing, under section 1818(d) of such Act, the monthly premium (under part A of title XVIII of such Act) for months in 1987.

SEC. 10202. APPLICABLE PERCENTAGE INCREASE IN PAYMENTS FOR INPATIENT HOSPITAL SERVICES.

(a) IN GENERAL.--Subclause (II) of section 1886(b)(3)(B)(i) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(i)) is amended to read as follows:

``(II) for fiscal year 1987, 1.3 percent, and for fiscal year 1988, the market basket percentage increase (as defined in clause (ii)) minus 2.0 percentage points, and''.

(b) CONFORMING AMENDMENTS.--(1) Section 1886(d)(3)(A) of such Act is amended by striking and 1986 and inserting , 1986, 1987, and 1988''.

(2) Section 1886(e)(4) of such Act is amended--

(A) by striking determine for each fiscal year (beginning with fiscal year 1987)'' and inserting ``recommend for fiscal year 1988 an appropriate change factor for inpatient hospital services for discharges in that fiscal year and shall determine for each subsequent fiscal year'', and

(B) by adding at the end the following new sentence: ``The percentage change for subsection (d) hospitals and subsection (d) Puerto Rico hospitals may be different from that for other hospitals and may vary among such other hospitals.''.

(3) Section 1886(e)(5) of such Act is amended--

(A) by striking ``June 1 before each fiscal year (beginning with fiscal year 1986)'' and inserting ``April 1 before fiscal year 1988 and the June 1 before each subsequent fiscal year'', and

(B) by inserting ``recommendation or'' before ``determination'' each place it appears.

(c) EFFECTIVE DATE.--The amendment made by subsection (a) shall apply to cost reporting periods beginning on or after October 1, 1986 and, for purposes of section 1886(d) of the Social Security Act, for discharges occurring on or after October 1, 1986.

(d) PROMULGATION OF NEW RATE.--The Secretary of Health and Human Services shall provide, within 30 days after the date of the enactment of this Act but in no case later than October 1, 1986, for the republication of the determination described in section 1886(e)(5) of the Social Security Act, taking into account the amendments made by this section, without regard to the provisions of chapter 5 of title 5, United States Code.

SEC. 10203. LIMITATION ON PAYMENTS FOR CAPITAL-RELATED COSTS FOR INPATIENT HOSPITAL SERVICES OF DRG HOSPITALS UNDER MEDICARE.

(a) IN GENERAL.--Section 1886(g) of the Social Security Act (42 U.S.C. 1395ww(g)) is amended by adding at the end the following new paragraph:

``(3)(A) Notwithstanding section 1861(v)(1), in determining the amount of the hospital capital payments (as defined in subparagraph (D)), the Secretary shall provide for a reduction by such percentage (in this section referred to as the `capital reduction percentage') in such payments as is necessary to provide that the aggregate amount of hospital capital payments attributable to portions of hospital cost reporting periods occuring in fiscal year 1987, in fiscal year 1988, and in fiscal year 1989, does not exceed 110 percent, 120 percent, and 130 percent, respectively, of the aggregate amount of such payments attributable to portions of hospital cost reporting periods occurring in fiscal year 1986, adjusted in accordance with subparagraph (C).

(B) The Secretary shall determine the capital reduction percentage based upon the best information available before the beginning of the fiscal year involved and interim and final payments shall be made on the basis of such percentage. Such percentage shall not be subject to change after the date it is promulgated in final form.

(C) In computing the hospital capital payments attributable to portions of cost reporting periods occurring in fiscal year 1986 in the computing the limitation on hospital capital payments under subparagraph (A) attributable to portions of cost reporting periods occurring in--

``(i) fiscal year 1987, there shall be excluded 25 percent,

``(ii) fiscal year 1988, there shall be excluded 50 percent,

``(iii) fiscal year 1989, there shall be excluded 75 percent,

of the amount of the hospital capital payments (attributable to portions of cost reporting periods occuring in fiscal year 1986) that are attributable to a return on equity capital.

``(D) In this paragraph, the term ``hospital capital payments'' means the payments that may be made under part A of this title with respect to the allowable capital-related costs (as defined by the Secretary) of inpatient hospital services for subsection (d) hospitals and subsection (d) Puerto Rico hospitals.''.

(b) PUBLICATION OF CAPITAL REDUCTION PERCENTAGE.--Section 1886(e)(4) of such Act is amended by inserting before the period at the end the following: ``and shall determine for each fiscal year the capital reduction percentage which should be effected under subsection (g)(3) for that fiscal year''.

(c) NO ADMINISTRATIVE OR JUDICIAL REVIEW.--Section 1886(d)(7) of such Act is amended--

(1) by striking ``and'' at the end of subparagraph (A),

(2) by striking the period at the end of subparagraph (B) and inserting ``, and'', and

(3) by adding at the end the following new subparagraph:

``(C) the determination of a capital reduction percentage under subsection (g)(3).''.

(d) EFFECTIVE DATE.--

(1) IN GENERAL.--The amendments made by this section shall apply to payments for capital-related costs attributable to portions of cost reporting periods occurring on or after October 1, 1986.

(2) TRANSITION.--The Secretary of Health and Human Services shall cause to have published in the Federal Register, by not later than 30 days after the date of the enactment of this Act or, if earlier, by October 1, 1986, the capital reduction percentage determined under section 1886(g)(3) for payments for capital-related costs attributable to portions of hospital cost reporting periods that occur during fiscal year 1987. In promulgating such percentage for such fiscal year, the provisions of chapter 5 of title 5, United States Code, and of chapter 35 of title 41 of such Code, shall not apply.

SEC. 10204. COVERAGE OF HOSPITALS IN PUERTO RICO UNDER A DRG PROSPECTIVE PAYMENT SYSTEM.

(a) IN GENERAL.--Section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) is amended by adding at the end the

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following new paragraph:

``(9)(A) Notwithstanding section 1814(b) but subject to the provisions of section 1813, the amount of the payment with respect to the operating costs of inpatient hospital services of a subsection (d) Puerto Rico hospital for inpatient hospital discharges in a fiscal year beginning on or after October 1, 1986, is equal to the sum of--

``(i) 75 percent of the Puerto Rico adjusted DRG prospective payment rate (determined under subparagraph (B) or (C)) for such discharges, and

``(ii) 25 percent of the average of--

``(I) the national adjusted DRG prospective payment rate (determined under paragraph (3)(D)) for hospitals located in an urban area, and

``(II) such rate for hospitals located in a rural area,

for such discharges, adjusted in the manner provided in paragraph (3)(E) for different area wage levels.

As used in this section, the term ``subsection (d) Puerto Rico hospital'' means a hospital that is located in Puerto Rico and that would be a subsection (d) hospital (as defined in paragraph (1)(B)) if it were located in one of the fifty States.

``(B) The Secretary shall determine a Puerto Rico adjusted DRG prospective payment rate, for each inpatient hospital discharge in fiscal year 1987 involving inpatient hospital services of a subsection (d) Puerto Rico hospital for which payment may be made under part A of this title. Such rate shall be determined for such hospitals located in urban or rural areas within Puerto Rico, as follows:

``(i) The Secretary shall determine the target amount (as defined in subsection (b)(3)(A)) for the hospital for the cost reporting period beginning in fiscal year 1986 and increase such amount by the applicable percentage increase (as defined in subsection (b)(3)(B)) for fiscal year 1987.

``(ii) The Secretary shall standardize the amount determined under clause (i) for each hospital by--

``(I) excluding an estimate of indirect medical education costs,

``(II) adjusting for variations among hospitals by area in the average hospital wage level, and

``(III) adjusting for variations in case mix among hospitals.

``(iii) The Secretary shall compute an average of the standardized amounts determined under clause (ii) for all hospitals located in an urban area and for all hospitals located in a rural area (as such terms are defined in paragraph (2)(D)).

``(iv) The Secretary shall reduce the average standardized amount by a proportion equal to the proportion (estimated by the Secretary) of the amount of payments under this paragraph which are additional payments described in subparagraph (D)(i) (relating to outlier payments) or in subparagraph (D)(v) (relating to disproportionate share payments) for subsection (d) Puerto Rico hospitals.

(v) For each discharge classified within a diagnosis-related group for hospitals located in an urban or rural area, respectively, the Secretary shall establish a Puerto Rico DRG prospective payment rate equal to the product of--

(I) the average standardized amount (computed under clause (iii) and reduced under clause (iv)) for hospitals located in an urban or rural area, respectively, and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.

(vi) The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs, of the Puerto Rico DRG prospective payment rate computed under clause (v) for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the Puerto Rican average hospital wage level.

(C) The Secretary shall determine a Puerto Rico adjusted DRG prospective payment rate, for each inpatient hospital discharge after fiscal year 1987 involving inpatient hospital services of a subsection (d) Puerto Rico hospital for which payment may be made under part A of this title. Such rate shall be determined for hospitals located in urban or rural areas within Puerto Rico as follows:

(i) The Secretary shall compute an average standardized amount for hospitals located in an urban area and for hospitals located in a rural area equal to the respective average standardized amount computed for the previous fiscal year under subparagraph (B)(iii) or under this clause, increased for fiscal year 1988 by the applicable percentage increase under subsection (b)(3)(B), and adjusted for subsequent fiscal years in accordance with the final determination of the Secretary under subsection (e)(4), and adjusted to reflect the most recent case-mix data available.

(ii) The Secretary shall reduce each of the average standardized amounts by a proportion equal to the proportion (estimated by the Secretary) of the amount of payments under this paragraph which are additional payments described in subparagraph (D)(i) (relating to outlier payments) or in subparagraph (D)(v) (relating to disproportionate share payments) for subsection (d) Puerto Rico hospitals.

(iii) For each discharge classified within a diagnosis-related group for hospitals located in an urban or rural area, respectively, the Secretary shall establish a Puerto Rico DRG prospective payment rate equal to the product of--

``(I) the average standardized amount (computed under clause (i) and reduced under clause (ii)) for hospitals located in an urban or rural area, respectively, and

``(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.

``(iv) The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs, of the Puerto Rico DRG prospective payment rate computed under clause (iii) for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the Puerto Rican average hospital wage level.

``(D) The following provisions of paragraph (5) shall apply to subsection (d) Puerto Rico hospitals receiving payment under this paragraph in the same manner and to the extent as they apply to subsection (d) hospitals receiving payment under this subsection:

``(i) Subparagraph (A) (relating to outlier payments), except that the total amount of additional payments made under this clause in a fiscal year may not be less than 5 percent nor more than 6 percent of the total payments projected or estimated to be made under this paragraph for discharges in that year.

``(ii) Subparagraph (B) (relating to payments for indirect medical education costs), except that for this purpose the sum of the amount determined under subparagraph (A) of this paragraph and the amount paid to the hospital under clause (i) of this subparagraph shall be substituted for the sum referred to in paragraph (5)(B)(i)(I).

``(iii) Subparagraph (C)(iii) (relating to exceptions and adjustments).

``(iv) Subparagraph (E) (relating to payments for costs of certified registered nurse anesthetists).

``(v) Subparagraph (F) (relating to disproportionate share payments), except that for this purpose the sum described in clause (ii) of this subparagraph shall be substituted for the sum referred to in paragraph (5)(F)(ii)(I).''.

(b) CONFORMING AMENDMENTS.--(1) The first sentence of section 1886(d)(5)(C)(i) of such Act is amended by inserting ``(other than under paragraph (9))'' after ``established under this subsection''.

(2) The second and third sentences of section 1886(d)(5)(C)(ii) of such Act are each amended by inserting ``(other than under paragraph (9))'' after ``payment amounts

under this subsection''.

(c) NO RESTANDARDIZATION OF NATIONAL LEVELS TO REFLECT INCLUSION OF PUERTO RICO.--The Secretary of Health and Human Services shall not restandardize or otherwise adjust the national DRG prospective payment rates otherwise determined under section 1886(d) of the Social Security Act to take into account changes in the payments provided to subsection (d) Puerto Rico hospitals under the amendment made by subsection (a).

(d) EFFECTIVE DATE.--The amendments made by this section shall apply to cost reporting periods beginning on or after October 1, 1986. The Secretary of Health and Human Services shall issue such regulations, by not later than October 1, 1986, as are necessary to implement such amendments in a timely manner, without regard to the provisions of chapter 5 of title 5, United States Code.

SEC. 10205. IMPROVING QUALITY OF CARE WITH RESPECT TO PART A SERVICES.

(a) REFINEMENT OF PROSPECTIVE PAYMENT SYSTEM.--

(1) DEVELOPMENT OF LEGISLATIVE PROPOSAL.--The Secretary of Health and Human Services shall develop and submit to Congress a specific legislative proposal to improve the classification and payment system under section 1886(d) of the Social Security Act (and, as appropriate, the system for payment of outliers under section 1886(d)(5)(A) of such Act) in order to assure that the amount of payment per discharge approximates the cost of medically necessary care provided in an efficient manner for individual patients or classes of patients with similar conditions.

(2) ACCOUNTING FOR SEVERITY OF ILLNESS.--In developing the proposal, the Secretary shall account for variations in severity of illness and case complexity which are not adequately accounted for by the current classification and payment system.

(3) DEADLINE.--The proposal shall be submitted to Congress by not later than 2 years after the date of the enactment of this Act.

(b) REQUIRING NOTICE OF HOSPITAL DISCHARGE RIGHTS.--

(1) REQUIREMENT FOR HOSPITALS TO PROVIDE STATEMENT.--Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)), as amended by section 10207(e)(6)(A) of this subtitle, is amended--

(A) by striking ``and'' at the end of the subparagraph (J),

(B) by striking the period at the end of subparagraph (K) and inserting ``, and'', and

(C) by inserting after subparagraph (K) the following new subparagraph:

``(L) in the case of hospitals, to provide to each individual who is entitled to benefits under part A (or to a legally responsible person or persons acting on the individual's behalf), at or about the time of the individual's admission as an inpatient to the hospital, a written statement (containing such language as the Secretary prescribes consistent with this paragraph) which explains--

``(i) the individual's rights to benefits for inpatient hospital services and for post-hospital services under this title,

``(ii) the circumstances under which such an individual will and will not be liable for charges for continued stay in the hospital,

``(iii) the individual's right to appeal denials of benefits for continued inpatient hospital services, including the practical steps to initiate such an appeal, and

``(iv) the individual's liability for payment for services if such a denial of benefits is upheld on appeal,

and which provides such additional information as the Secretary may specify.''

(2) EFFECTIVE DATE.--The Secretary of Health and Human Services shall first prescribe the language required under section 1866(a)(1)(L) of the Social Security Act not later than six months after the date of the enactment of this Act. The requirement of such section shall apply to admissions to hospitals occurring on such date (not later than 60 days after the date such language is first prescribed) as the Secretary shall provide.

(c) REQUIRING HOSPITALS TO PROVIDE DISCHARGE PLANNING PROCESS.--

(1) REQUIREMENT AS CONDITION OF PARTICIPATION.--Section 1861(e)(6) of the Social Security Act (42 U.S.C. 1395x(e)(6)) is amended--

(A) by inserting ``(A)'' after ``(6)'', and

(B) by inserting before the semicolon at the end the following: ``and (B) has in place a discharge planning process that meets the requirements of subsection (ee)''.

(2) DISCHARGE PLANNING PROCESS DEFINED.--Section 1861 of such Act is further amended by adding at the end the following new subsection:

``Discharge Planning Process

``(ee)(1) A discharge planning process of a hospital shall be considered sufficient if it is applicable to services furnished by the hospital to individuals entitled to benefits under this title and if it meets the guidelines and standards established by the Secretary under paragraph (2).

``(2) The Secretary shall develop guidelines and standards for the discharge planning process in order to ensure a timely and smooth transition to the most appropriate type of and setting for post-hospital or rehabilitative care. The guidelines and standards shall include the following:

(A) The hospital must identify, at an early stage of hospitalization, those patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning.

(B) Hospitals must provide a discharge planning evaluation for patients identified under subparagraph (A) and for other patients upon the request of the patient, patient's representative, or patient's physician.

(C) Any discharge planning evaluation must be made on a timely basis to ensure that appropriate arrangements for post-hospital care will be made before discharge and to avoid unnecessary delays in discharge.

(D) A discharge planning evaluation must include an evaluation of a patient's likely need for appropriate post-hospital services and the availability of those services.

(E) The discharge planning evaluation must be included in the patient's medical record for use in establishing an appropriate discharge plan and the results of the evaluation must be discussed with the patient (or the patient's representative).

(F) Upon the request of a patient's physician, the hospital must arrange for the development and initial implementation of a discharge plan for the patient.

(G) Any discharge planning evaluation or discharge plan required under this paragraph must be developed by, or under the supervision of, a registered professional nurse, social worker, or other appropriately qualified personnel.

(3) EFFECT OF ACCREDITATION.--The second sentence of section 1865(a) of such Act (42 U.S.C. 1395bb(a)) is amended--

(A) by inserting ``, requires a discharge planning process (or imposes another requirement which serves substantially the same purpose),'' after ``the same purpose)'', and

(B) by inserting ``clause (A) or (B) of'' after ``comply also with''.

(4) EFFECTIVE DATE.--The amendments made by this subsection shall apply to hospitals as of one year after the date of the enactment of this Act.

(d) REVIEW OF STANDARDS FOR MEDICARE CONDITIONS OF PARTICIPATION FOR ASSURING QUALITY OF INPATIENT HOSPITAL SERVICES.--The Secretary of Health and Human Services shall arrange for a study of the adequacy of the standards used for hospitals, for purposes of meeting the conditions of participation under title XVIII of the Social Security Act, in assuring the quality of services furnished in hospitals. The

Secretary shall report to Congress on the results of the study by not later than 2 years after the date of the enactment of this Act.

(e) STUDY OF PAYMENT FOR ADMINISTRATIVELY NECESSARY DAYS.--

(1) IN GENERAL.--The Secretary of Health and Human Services shall conduct a study to determine whether a payment should be made (in a budget-neutral manner under title XVIII of such Act to hospitals receiving payments under section 1886(d) of such Act) to a hospital for administratively necessary days, separate from the per-discharge and outlier payments made under such section.

(2) ADMINISTRATIVELY NECESSARY DAYS DEFINED.--In this subsection, an ``administratively necessary day'' is a day of continued inpatient hospital stay, for an individual entitled to benefits under part A of title XVIII of the Social Security Act, necessitated by a delay in obtaining placement for the individual in a skilled nursing facility.

(3) CONSIDERATIONS IN CONDUCTING STUDY.--In conducting the study, the Secretary shall consider--

(A) the need for such a payment in order to minimize--

(i) the disproportionate financial impact of current law on certain hospitals (or hospitals in certain locations) due to difficulties in arranging for appropriate post-hospital care, such as difficulties resulting from a shortage of beds in skilled nursing facilities where those hospitals are located and from the source of payment for such care, and

(ii) the risk of inappropriate discharge to a non-institutional or inappropriate institutional setting of individuals who need post-hospital services in a skilled nursing facility, and

(B) the administrative mechanisms that can be used to prevent inappropriate payments for administratively necessary days.

(4) REPORT ON STUDY.--The Secretary shall report to Congress on the results of the study not later than January 1, 1988.

(f) CONTINUING OF FAVORABLE PRESUMPTION OF WAIVER OF LIABILITY FOR SKILLED NURSING FACILITIES, HOME HEALTH AGENCIES, AND HOSPICE PROGRAMS.--

(1) IN GENERAL.--Section 1879 of the Social Security Act (42 U.S.C. 1395pp) is amended by adding at the end the following new subsection:

``(f)(1)(A) A skilled nursing facility which meets the applicable requirements of paragraphs (3) and (4) shall be presumed to meet the requirement of subsection (a)(2) with respect to denials of coverage by reason of section 1862(a)(1) or (9).

(B) A home health agency which meets the applicable requirements of paragraphs (3) and (4) shall be presumed to meet the requirement of subsection (a)(2) with respect to denials of coverage by reason of section 1862(a)(1) or (9).

(C) A hospice program which meets the applicable requirements of paragraphs (3) and (4) shall be presumed to meet the requirement of subsection (a)(2) with respect to denials of coverage by reason of section 1862(a)(1) or (9).

(2) The presumption of paragraph (1) with respect to specific services may be rebutted by actual or imputed knowledge of the facts described in subsection (a)(2), including any of the following:

(A) Notice by the fiscal intermediary of the fact that payment may not be made under this title with respect to the services.

(B) In the case of a skilled nursing facility, the committee or group responsible for the conduct of utilization review for the facility has informed the facility that payment may not be made under this title with respect to the services.

(C) It is clear and obvious that the provider should have known at the time the services were furnished that they were excluded from coverage.

(3) The requirements of this paragraph are as follows:

(A) The facility, agency, or program complies with requirements of the Secretary under this title respecting timely submittal of bills for payment and medical documentation.

(B) The facility, agency, or program has reasonable procedures to notify promptly each patient (and the patient's physician) where it is determined that a patient is being or will be furnished items or services which are excluded from coverage under this title.

(4) The requirement of this paragraph is that, on the basis of bills submitted during the previous quarter, the rate of denial of bills by reason of section 1862(a)(1) or (9) for--

(A) a skilled nursing facility does not exceed 5 percent, computed based on days of post-hospital extended care services billed,

(B) a home health agency does not exceed 2.5 percent, computed based on visits for home health services billed, or

(C) a hospice program does not exceed 2.5 percent, computed based on visits for hospice care billed.

(5) The Secretary shall report annually to Congress--

(A) information on the frequency and distribution (by type of provider) of denials referred to in paragraph (4), including--

(i) the reasons for such denials,

``(ii) the extent to which payments were nonetheless made because of this section, and

``(iii) the rate of reversals of such denials, and

``(B) such other information as may be appropriate to evaluate the appropriateness of the percentage standards established under paragraph (4).

``(6) In this subsection, the term `fiscal intermediary' means, with respect to a skilled nursing facility, home health agency, or hospice program an agency or organization with an agreement under section 1816 with respect to the facility, agency, or program.''.

(2) REPEALING DUPLICATIVE PROVISIONS.--Section 9205 of the Consolidated Omnibus Budget Reconciliation Act of 1985, and subsection (c) of section 9126 of such Act, are repealed.

(3) EFFECTIVE DATE.--(A) Except as provided in subparagraph (B), the amendments made by paragraphs (1) and (2) shall apply to services furnished on or after the date of the enactment of this Act, and before October 1, 1989.

(B) The amendments made by paragraph (1) shall apply to hospice care furnished (i) on or after the first day of the first month that begins at least 6 months after the date of the enactment of this Act and (ii) before October 1, 1989.

(g) EXTENSION OF WAIVER OF LIABILITY PROVISIONS TO CERTAIN COVERAGE DENIALS FOR HOME HEALTH SERVICES.--

(1) IN GENERAL.--Section 1879 of the Social Security Act (42 U.S.C. 1395pp), as amended by subsection (f), is further amended--

(A) in subsection (a)(1), by inserting ``or by reason of a coverage denial described in subsection (g)'' after ``section 1862(a)(1) or (9)'';

(B) in the first sentence of subsection (a), by inserting ``and as though the coverage denial described in subsection (g) had not occurred'' before the period at the end;

(C) in the third sentence of subsection (a), by inserting ``or by reason of a coverage denial described in subsection (g)'' after ``section 1862(a)(1) or (9)'';

(D) in subsection (c), by inserting ``or by reason of a coverage denial described in subsection (g)'' after ``section 1862(a)(1) or (9)'';

(E) in subsection (f)(1)(B)--

(i) by inserting ``(i)'' after ``applicable requirements'', and

(ii) by inserting before the period at the end the following: ``or (ii) of paragraphs (3) and (5) shall be presumed to meet the requirement of subsection (a)(2) with respect to any coverage denial described in subsection (g)'';

(F) in subsection (f)--

(i) in paragraph (5), by striking ``paragraph (4)'' each place it appears and inserting ``paragraphs (4) and (5)'',

(ii) by redesignating paragraphs (5) and (6) as paragraph (6) and (7), respectively, and

(iii) by inserting after paragraph (4) the following new paragraph:

``(5) The requirement of this paragraph is that, on the basis of bills submitted by a home health agency during the previous quarter, the rate of denial of bills for the agency by reason of a coverage denial described in subsection (g) does not exceed 2.5 percent, computed based on visits for home health services billed.''; and

(G) by adding at the end the following new subsection:

``(g) The coverage denial described in this subsection is, with respect to the provision of home health services to an individual, a failure to meet the requirements of section 1814(a)(2)(C) or section 1835(a)(2)(A) in that the individual--

``(1) is or was not confined to his home, or

``(2) does or did not need skilled nursing care on an intermittent basis or physical, speech, or occupational therapy.''.

(2) EFFECTIVE DATE.--The amendments made by paragraph (1) shall apply to services furnished on or after the first day of the first month that begins more than 90 days after the date of the enactment of this Act; except that the amendments made by paragraphs (1)(E) and (1)(F)(iii) shall not apply to services furnished on or after October 1, 1989.

(h) DEVELOPMENT OF UNIFORM NEEDS ASSESSMENT INSTRUMENT.--

(1) DEVELOPMENT.--The Secretary of Health and Human Services shall develop a uniform needs assessment instrument that--

(A) evaluates--

(i) the functional capacity of an individual,

(ii) the nursing and other care requirements of the individual to meet health care needs and to assist with functional incapacities, and

(iii) the social and familial resources available to the individual to meet those requirements; and

(B) can be used by discharge planners, hospitals, nursing facilities, other health care providers, and fiscal intermediaries in evaluating an individual's need for post-hospital extended care services, home health services, and long-term care services of a health-related or supportive nature.

The Secretary may develop more than one such instrument for use in different situations.

(2) ADVISORY PANEL.--The Secretary shall develop any

instrument in consultation with an advisory panel, appointed by the Secretary, that includes experts in the delivery of post-hospital extended care services, home health services, and long-term care services and includes representatives of hospitals, of physicians, of skilled nursing facilities, of home health agencies, of long-term care providers, of fiscal intermediaries, and of medicare beneficiaries.

(3) REPORT ON INSTRUMENT.--The Secretary shall report to Congress, not later than 1 year after the date of the enactment of this Act, on the instrument or instruments developed under this section. The report shall include an evaluation of the advantages and disadvantages of using the instrument or instruments as the basis for determining whether payment should be made for post-hospital extended care services and home health services provided to individuals entitled to benefits under part A of title XVIII of the Social Security Act.

(i) EXPEDITED REVIEW BY FISCAL INTERMEDIARIES.--

(1) IN GENERAL.--Section 1879 of the Social Security Act (42 U.S.C. 1395pp), as amended by subsections (f) and (g), is further amended by adding at the end the following new subsection:

``(h) The Secretary shall develop procedures to expedite the determination of whether initial claims submitted for post-hospital extended care services, home health services, and hospice care provided (or to be provided) to an individual may be reimbursed under this title, so as to minimize the time between (1) when the provider first provides the services to the individual, and (2) when the provider first receives notice of an initial determination on whether or not payment may be made under this title for some or all of the services provided the individual.''

(2) EFFECTIVE DATE.--The Secretary of Health and Human Services shall provide for the expedited procedures described in section 1879(h) of the Social Security Act not later than one year after the date of the enactment of this Act.

(j) INCLUDING IN ANNUAL REPORTS ON PROSPECTIVE PAYMENT SYSTEM INFORMATION ON QUALITY OF POST-HOSPITAL CARE.--

(1) IN GENERAL.--Section 603(a)(2) of the Social Security Amendments of 1983 is amended--

(A) by striking ``1987'' in subparagraph (A) and inserting ``1989'', and

(B) by adding at the end the following new subparagraph:

``(E) In each annual report to Congress under subparagraph (A), the Secretary shall include--

``(i) an evaluation of the adequacy of the procedures for assuring quality of post-hospital services furnished under title XVIII of the Social Security Act, ``(ii) an assessment of problems that have prevented groups of medicare beneficiaries (including those eligible for medical assistance under title XIX of such Act) from receiving appropriate post-hospital services covered under such title, and

``(iii) information on reconsiderations and appeals taken under title XVIII of such Act with respect to payment for post-hospital services.''.

(2) EFFECTIVE DATE.--The amendment made by paragraph (1)(B) shall apply to reports for years beginning with 1986.

(k) PRIOR AUTHORIZATION DEMONSTRATION PROJECT.--

(1) IN GENERAL.--The Secretary of Health and Human Services shall conduct a demonstration program concerning prior authorization for post-hospital extended care services and home health services furnished under part A of title XVIII of the Social Security Act.

(2) SCOPE.--The program shall include at least four projects and shall be implemented by not later than July 1, 1987.

(3) CONSULTATION.--The program shall be developed in consultation with an advisory panel that includes experts in the delivery of post-hospital extended care services, home health services, and long-term care services and includes representatives of hospitals, of physicians, of skilled nursing facilities, of home health agencies, of long-term care providers, of fiscal intermediaries, and of medicare beneficiaries.

(4) EVALUATION AND REPORT.--The Secretary shall evaluate the demonstration program conducted under this subsection and shall report to Congress on such evaluation no later than January 1, 1989. Such evaluation and report shall address--

(A) the administrative and program costs for prior authorization across demonstration projects and in comparison to administrative and program costs under the current system of retroactive review, including costs for uncovered services paid under the waiver of liability which would not be incurred under prior authorization;

(B) impact of prior authorization on access to and availability of extended care services and home health services in comparison to the current system (including costs to providers) and on timely discharge of hospital inpatients; and

(C) accuracy and associated cost savings of payment determinations and rates of claim reversals under prior authorization versus the current system.

(5) FUNDING.--Expenditures made for the demonstration program shall be made from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act. Grants and payments under contracts may be made either in

advance or by way of reimbursement, as may be determined by the Secretary, and shall be made in such installments and on such conditions as the Secretary finds necessary to carry out the purpose of this subsection.

(6) WAIVER OF MEDICARE REQUIREMENTS.--The Secretary shall waive compliance with such requirements of title XVIII of the Social Security Act to the extent and for the period the Secretary finds necessary for the conduct of the demonstration program.

SEC. 10206. OFF-BUDGET TREATMENT OF FEDERAL HOSPITAL INSURANCE TRUST FUND IN FISCAL YEAR 1987.

(a) EFFECTIVE IN FISCAL YEAR 1987.--Section 710 of the Social Security Act (as amended by section 261 of Public Law 99-177) is amended--

(1) by amending subsection (b) to read as follows:

``(b)(1) The receipts and disbursements of the Federal Hospital Insurance Trust Fund and the taxes imposed under sections 1401(b), 3101(b), and 3111(b) of the Internal Revenue Code of 1954, shall not be included in the totals of the budget of the United States Government as submitted by the President or of the congressional budget and shall be exempt from any general budget limitation imposed by statute on expenditures and net lending (budget outlays) of the United States Government.

(2) The disbursements of the Federal Supplementary Medical Insurance Trust Fund shall be treated as a separate major functional category in the budget of the United States Government as submitted by the President and in the congressional budget, and the receipts of such Trust Fund shall be set forth separately in such budgets.'', and

(2) in subsection (c), by striking ``or the Federal Disability Insurance Trust Fund, or for payments from either'' and inserting ``, the Federal Disability Insurance Trust Fund, or the Federal Hospital Insurance Trust Fund, or for payments from any''.

(b) EFFECTIVE DATE.--The amendments made by subsection (a) shall apply with respect to fiscal years beginning after September 30, 1986, and ending before October 1, 1992.

SEC. 10207. TECHNICAL AMENDMENTS AND MISCELLANEOUS PROVISIONS RELATING TO PART A.

(a) ONE-YEAR EXTENSION OF PASS-THROUGH FOR COSTS OF CERTIFIED REGISTERED NURSE ANESTHETISTS.--Section 2312(c) of the Deficit Reduction Act of 1984 is amended by striking ``October 1, 1987'' and inserting ``October 1, 1988''.

(b) 4-YEAR DESIGNATION PERIOD FOR RURAL REFERRAL CENTERS.--If the Secretary of Health and Human Services classifies or has classified a hospital located in a rural area as a regional referral center under section 1886(d)(5)(C)(i) of the Social Security Act, the Secretary shall not terminate or change such classification before the end of the 4th cost reporting period for which the classification is in effect.

(c) TEMPORARY WAIVER OF INPATIENT LIMITATIONS FOR THE CONNECTICUT HOSPICE, INC.--With respect to the Connecticut Hospice, Inc., for hospice care provided before October 1, 1988, the reference in section 1861(dd)(2)(A)(iii) of the Social Security Act (42 U.S.C. 1395x(dd)(2)(A)(iii)) to ``20 percent'' is deemed a reference to ``50 percent''.

(d) MASSACHUSETTS MEDICARE REPAYMENT.--The Secretary of Health and Human Services shall not, on or after the date of the enactment of this section and before January 1, 1988, recoup from, or otherwise reduce payments to, hospitals in the State of Massachusetts because of alleged overpayments to such hospitals under part A of title XVIII of the Social Security Act which occurred during the period of the State-wide hospital reimbursement demonstration project conducted in that State, between October 1, 1982, and June 30, 1986, under section 402 of the Social Security Amendments of 1967 and section 222 of the Social Security Amendments of 1972.

(e) PART A COBRA TECHNICAL CORRECTIONS.--

(1) CLARIFICATION OF INDIRECT MEDICAL EDUCATION COSTS LANGUAGE.--(A) Paragraph (2)(C)(i) of subsection (d) of section 1886 of the Social Security Act (42 U.S.C. 1395ww) is amended by striking ``(taking into account, for discharges occurring after September 30, 1986, the amendments made by section 9104(a) of the Medicare and Medicaid Budget Reconciliation Amendments of 1985)''.

(B) Paragraph (3)(A) of such subsection is amended by adding at the end the following: ``If the formula under paragraph (5)(B) for determining payments for the indirect costs of medical education is changed for any fiscal year, the Secretary shall readjust the standardized amounts previously determined for each hospital to take into account the changes in that formula.''.

(C) Clause (ii) of paragraph (3)(C) of such subsection is amended to read as follows:

``(ii) REDUCING FOR SAVINGS FROM AMENDMENT TO INDIRECT TEACHING ADJUSTMENT FOR DISCHARGES AFTER SEPTEMBER 30, 1986.--The Secretary shall further reduce each of the average standardized amounts by a proportion equal to the proportion (estimated by the Secretary) of the amount of payments under this subsection based on DRG prospective payment amounts which is the difference between--

``(I) the sum of the additional payment amounts under paragraph (5)(B) (relating to indirect costs of medical education) if the indirect teaching adjustment factor were equal to 1.159r (as `r' is defined in paragraph (5)(B)(ii)), and

``(II) that sum using the factor specified in paragraph (5)(B)(ii)(II).''.

(D)(i) Except as provided in clause (ii), the amendments made by this paragraph apply to discharges occurring on or after October 1, 1986.

(ii) The amendments made by this paragraph shall not be first applied to discharges occurring as of a date unless, for discharges occurring on that date, the amendments made by section 9105(a) of the Consolidated Omnibus Budget Reconcilation Act of 1985 (incorporating the amendments made by paragraph (2) of this subsection) are also being applied.

(2) CLARIFICATION OF DISPROPORTIONATE SHARE LANGUAGE.--(A) Paragraph (2)(C) of subsection (d) of section 1886 of the Social Security Act (42 U.S.C. 1395ww), as amended by section 9105(b) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (in this section referred to as ``COBRA'') is amended--

(i) by adding ``and'' at the end of clause (ii),

(ii) by striking ``, and'' at the end of clause (iii) and inserting a period, and

(iii) by striking clause (iv).

(B) Paragraph (3)(C) of such subsection is amended by adding at the end the following:

``(iii) REDUCING FOR DISPROPORTIONATE SHARE PAYMENTS.--The Secretary shall further reduce each of the average standardized amounts by reducing the standardized amount for each hospital (as previously determined without regard to this clause) by a proportion equal to the proportion (established by the Secretary) of the amount of payments under this subsection based on DRG prospective payment amounts which are additional payments described in paragraph (5)(F) (relating to disproportionate share payments) for subsection (d) hospitals.''.

(C) Paragraph (5)(F)(vi)(I) of such subsection is amended--

(i) by striking ``supplementary'' and inserting ``supplemental'', and

(ii) by striking ``fiscal year'' and inserting ``period''.

(D) The amendments made by subparagraph (C) apply to discharges occurring on or after May 1, 1986, and the amendments made by subparagraphs (A) and (B) apply to discharges occurring on or after October 1, 1986.

(3) CLARIFICATION THAT ALL MEDICARE PARTICIPATING HOSPITALS ARE REQUIRED TO MEET EMERGENCY CARE REQUIREMENTS.--Section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)), as inserted by section 9121(b) of COBRA, is amended by striking ``and has, under the agreement, obligated itself to comply with the requirements of this section''.

(4) APPROPRIATE ANNUAL PERIODS FOR SKILLED NURSING

FACILITY PROSPECTIVE PAYMENTS.--(A) Section 1888(d)(1) of the Social Security Act (42 U.S.C. 1395yy(d)(1)), as added by section 9126(a) of COBRA, is amended by striking ``fiscal year'' each place it appears and inserting ``cost reporting period''.

(B) Section 1888(d)(4) of such Act is amended--

(i) in the first sentence, by striking ``each fiscal year'' and inserting ``cost reporting periods beginning in a fiscal year'', and

(ii) in the second sentence, by striking ``fiscal year'' and all that follows up to the period and inserting ``cost reporting period no later than 30 days before the beginning of that period''.

(C) Section 9126(d)(1) of COBRA is amended by striking ``fiscal years'' and inserting ``cost reporting periods''.

(D) The amendments made by subparagraphs (A) and (B) apply to cost reporting periods beginning on or after October 1, 1986.

(5) TREATMENT OF CERTAIN STATE AND LOCAL CAMPAIGN WORKERS WITH RESPECT TO THE HOSPITAL INSURANCE TAX.--(A) Section 3121(u)(2)(B)(ii) of the Internal Revenue Code of 1954 is amended--

(i) by striking ``or'' at the end of subclause (III),

(ii) by striking the period at the end of subclause (IV) and inserting ``, or'', and

(iii) by adding at the end the following:

``(V) by an election official or election worker if the remuneration paid in a calendar year for such service is less than $100.''

(B) Section 210(p)(2) of the Social Security Act (42 U.S.C. 410(p)(2)) is amended--

(i) by striking ``or'' at the end of subparagraph (C),

(ii) by striking the period at the end of subparagraph (D) and inserting ``, or'', and

(iii) by adding at the end the following:

``(E) by an election official or election worker if the remuneration paid in a calendar year for such service is less than $100.''.

(C) The amendments made by this paragraph shall apply to services performed after March 31, 1986.

(6) MISCELLANEOUS PROVISIONS.--(A) Paragraph (1) of section 1866(a) of the Social Security Act (42 U.S.C. 1395cc(a)) is amended--

(i) by striking the ``and'' inserted at the end of subparagraph (I) by section 9122(a)(2) of COBRA,

(ii) by striking the period at the end of subparagraph (J) and inserting ``, and'', and

(iii) by redesignating the subparagraph (I) inserted by section 9403(b) of COBRA as subparagraph (K) and transferring and inserting such subparagraph after subparagraph (J).

(B) The amendments made by subparagraph (A) are effective as if they had been included in the enactment of COBRA.

(C) Effective on the date of the enactment of Public Law 99-107, in applying section 5(a) of such Act, a cost reporting period beginning on September 28, 29, or 30 is deemed to begin on October 1 and any reference to September 30 is deemed a reference to September 27.

PART 2--PROVISIONS RELATING TO PARTS A AND B

SEC. 10221. ELIMINATION OF PERIODIC INTERIM PAYMENT SYSTEM (PIP) FOR DRG HOSPITALS AND PROMPT PAYMENT FOR MEDICARE PROVIDERS.

(a) ELIMINATION OF PIP FOR PPS HOSPITALS.--

(1) IN GENERAL.--Section 1815(a) of the Social Security Act (42 U.S.C. 1395g(a)) is amended--

(A) by inserting ``(1)'' after ``(a)'', and

(B) by adding at the end the following new paragraph:

``(2)(A) Except as provided in subparagraph (B), the Secretary shall provide payment under this part for inpatient hospital service furnished by a subsection (d) hospital (as defined in section 1886(d)(1)(B), and including a distinct psychiatric or rehabilitation unit of such a hospital) only on the basis of actual bills submitted by the hospital and not on a periodic interim payment basis.

``(B) Subparagraph (A) shall not apply, and the Secretary shall permit payment on a periodic interim payment basis--

``(i) to a subsection (d) hospital during the period it is--

``(I) being paid additional amounts under section 1886(d)(5)(F) (relating to disproportionate share payments), or

``(II) a sole community hospital (as defined in section 1886(d)(5)(C)(ii)); and

``(ii) to a hospital which is receiving payment under a State hospital reimbursement system under section 1814(b)(3) or 1886(c), if payment on a periodic interim payment basis is an integral part of such reimbursement system.

``(C) In the case of a subsection (d) hospital which has significant cash flow problems resulting from operations of its intermediary or from unusual circumstances of the hospital's operation, the Secretary shall make available appropriate accelerated payments.''.

(2) EFFECTIVE DATE.--The amendments made by paragraph (1) shall be effective with respect to payments for discharges occurring on or after July 1, 1987.

(b) REQUIRING TIMELY PAYMENT OF PROPERLY SUBMITTED MEDICARE CLAIMS UNDER PART A.--

(1) IN GENERAL.--Section 1816(c) of the Social Security Act (42 U.S.C. 1395h(c)) is amended--

(A) by inserting ``(1)'' after ``(c)'', and

(B) by adding at the end the following new paragraph:

``(2)(A) Each agreement under this section shall provide that, in cases of claims for which payment under this part is not made on a periodic interim payment basis under section 1815(a)--

``(i) if payment is not made on or before the 22nd calendar day after the date on which a clean claim is received, interest on the claim shall be paid at the rate used for purposes of section 3902(a) of title 31, United States Code (relating to interest penalties for failure to make prompt payments) for the period beginning on the day after the required payment date and ending on the date on which payment is made;

``(ii) the agency or organization shall notify the entity submitting the claim, within 22 calendar days after the date the claim is received, of any defect, impropriety, or circumstance that prevents the claim from being treated as a clean claim;

``(iii) if notice required under clause (ii) is not provided on a timely basis with respect to a claim and payment is subsequently made on the claim, interest on the amount determined to be payable shall be made (at the rate described in clause (i)) for the period beginning on the day after the required notice date and ending on the date on which payment is made or the date the notice is provided, whichever date is earlier; and

``(iv) the agency or organization will be reimbursed for the amount of interest paid under this subparagraph from amounts made available for Federal administrative costs to carry out this part (other than such amounts as are made available for intermediary agreements under this section).

``(B) In this paragraph, the term `clean claim' means a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this part.''.

(2) EFFECTIVE DATE.--The amendments made by paragraph (1) shall apply to claims received on or after July 1, 1987.

(c) PROMPT PAYMENT FOR MEDICARE PHYSICIANS AND SUPPLIERS.--

(1) IN GENERAL.--Section 1842(c) of the Social Security Act (42 U.S.C. 1395u(c)) is amended--

(A) by inserting ``(1)'' after ``(c)'', and

(B) by adding at the end the following new paragraph:

``(2)(A) Each contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B), shall that, in cases of claims for which payment under this part is not made on a periodic interim payment basis described in section 1815(a)--

“(i) if payment is not made on or before the 22nd calendar day (or the 11th calendar day, the case of a claim for services furnished by a participating physician or supplier)after the date on which a clean claim is received, interest on the claim shall be paid at the rate used for purposes of section 3902(a) of title 31, United States Code (relating to interest penalties for failure to make prompt payments) for the period beginning on the day after the required payment date and ending on the date on which payment is made;

“(ii) the carrier shall notify the entity submitting the claim, within 22 calendar days (or within 11 calendar days, in the case of a claim for services furnished by a participating physician or supplier) after the date the claim is received, of any defect, impropriety, or circumstance that prevents the claim from being treated as a clean claim;

“(iii) if notice required under clause (ii) is not provided on a timely basis with respect to a claim and payment is subsequently made on the claim, interest on the amount determined to be payable shall be made (at the rate described in clause (i)) for the period beginning on the day after the required notice date and ending on the date on which payment is made or the date the notice is provided, whichever date is earlier; and

“(iv) the carrier will be reimbursed for the amount of interest paid under this subparagraph from amounts made available for Federal administrative costs to carry out this part (other than such amounts as are made available for carrier contracts under this section).

“(B) In this paragraph, the term ‘clean claim’ means a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this part.”.

(2) EFFECTIVE DATE.--The amendments made by paragraph (1) shall apply to claims received on or after October 1, 1987.

SEC. 10222. HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS.

(a) REPEAL OF “2 FOR 1” CONVERSION REQUIREMENT FOR CERTAIN HEALTH MAINTENANCE ORGANIZATIONS.--Section 114(c)(2) of the Tax Equity and Fiscal Responsibility Act of 1982 is amended by adding at the end the following new subparagraph:

“(E) The preceding provisions of this paragraph shall not to apply to payments made for current, nonrisk medicare enrollees for months beginning with April 1987.”.

(b) REQUIRING THE PROVISION OF AN EXPLANATION OF ENROLLEE

RIGHTS.--

(1) IN GENERAL.--Subsection (c)(3) of section 1876 of the Social Security Act (42 U.S.C. 1395mm) is amended by adding at the end the following new subparagraph:

``(E) Each eligible organization shall provide each enrollee, at the time of enrollment and not less frequently than annually thereafter, an explanation of the enrollee's rights under this section, including an explanation of--

``(i) the enrollee's rights to benefits from the organization,

``(ii) the restrictions on payments under this title for services furnished other than by or through the organization,

``(iii) out-of-area coverage provided by the organization,

``(iv) the organization's coverage of emergency services and urgently needed care, and

``(v) appeal rights of enrollees.''.

(2) EFFECTIVE DATE.--The amendment made by paragraph (1) shall take effect on January 1, 1987, and shall apply to enrollments effected on or after such date.

(c) RESTRICTING WAIVER OF REQUIREMENT OF 50 PERCENT NON-MEDICARE ENROLLMENT.--

(1) RESTRICTION ON NEW WAIVERS.--Paragraph (2) of subsection (f) of such section is amended by striking ``if'' and all that follows through the end and inserting the following: ``if more than 50 percent of the population of the area served by the organization consists of individuals who are entitled to benefits under this title or under a State plan approved under title XIX.''.

(2) SANCTIONS FOR NONCOMPLIANCE.--Such subsection is further amended by adding at the end the following new paragraph:

``(3) If the Secretary determines that an eligible organization has failed to comply with the requirements of this subsection, the Secretary may provide for the suspension of enrollment of individuals under this section with the organization after the date the Secretary notifies the organization of such noncompliance.''.

(3) EFFECTIVE DATES.--

(A) NEW RESTRICTION.--The amendment made by paragraph (1) shall apply to modifications and waivers granted after the date of the enactment of this Act.

(B) SANCTIONS FOR NONCOMPLIANCE.--The amendment made by paragraph (2) shall take effect on the date of the enactment of this Act.

(C) TREATMENT OF CURRENT WAIVERS.--In the case of an eligible organization described in subparagraph (D), the organization shall make, and continue to make, reasonable efforts to meet scheduled enrollment goals, consistent with a schedule of compliance approved by the Secretary of Health and Human Services. If the Secretary determines that the organization--

(i) has complied, or made significant progress towards compliance, with such schedule of compliance, the Secretary may extend such waiver, or

(ii) has not complied with such schedule, the Secretary may provide for the suspension of enrollment, under section 1876 of the Social Security Act, of individuals with the organization after the date the Secretary notifies the organization of such noncompliance.

(D) ORGANIZATION COVERED.--An eligible organization described in this subparagraph is an eligible organization that--

(i) as of the date of the enactment of this Act, has been granted, under paragraph (2) of section 1876(f) of the Social Security Act, a modification or waiver of the requirement imposed by paragraph (1) of that section, but

(ii) does not meet the requirement for such modification or waiver under the amendment made by paragraph (1) of this subsection,

and includes a successor to such an organization.

(d) REQUIRING PROMPT PAYMENT OF CLAIMS.--

(1) IN GENERAL.--Subsection (g) of such section is amended by adding at the end the following new paragraph:

``(6)(A) A risk-sharing contract under this section shall require the eligible organization to provide prompt payment (consistent with the provisions of sections 1816(c)(2) and 1842(c)(2)) of claims submitted for covered services and supplies furnished to individuals enrolled under this section, if the services or supplies are not furnished under a contract between the organization and the provider or supplier.

``(B) In the case of an eligible organization which the Secretary determines, after notice and opportunity for a hearing, has failed to make payments of amounts in compliance with subparagraph (A), the Secretary may provide for direct payment of the amounts owed to providers and suppliers for such covered services furnished to individual enrolled under this section under the contract. If the Secretary provides for such direct payments, the Secretary shall provide for an appropriate reduction in the amount of payments otherwise made to the organization under this section to reflect the amount of the Secretary's payments (and costs incurred by the Secretary in making such payments).''.

(2) EFFECTIVE DATE.--The amendment made by paragraph (1) shall apply to risk-sharing contracts under section 1876 of the Social Security Act with respect to services furnished on

or after July 1, 1987.

(e) Requiring Access to Financial Records and Disclosure of Internal Loans.--

(1) In General.--Subsection (i)(3)(C) of such section is amended--

(A) by striking ``and'' at the end,

(B) by inserting ``(i)'' after ``(C)'', and

(C) by adding at the end the following new clauses:

``(ii) shall require the organization to provide and supply information (described in section 1866(b)(2)(C)(ii)) in the manner such information is required to be provided or supplied under that section;

``(iii) shall require the organization to notify the Secretary of loans and other special financial arrangements which are made between the organization and subcontractors, affiliates, and related parties; and''.

(2) Effective Date.--The amendments made by paragraph (1) shall apply to contracts as of January 1, 1987.

(f) Authority to Impose Civil Money Penalties.--Subsection (i) of such section is amended by adding at the end the following new paragraph:

``(6)(A) Any eligible organization with a risk-sharing contract under this section that fails substantially to provide medically necessary items and services that are required (under law or such contract) to be provided to individuals covered under such contract, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) these individuals, is subject to a civil money penalty of not more than $2,000 for each such failure.

``(B) The provisions of section 1128A (other than subsection (a)) shall apply to a civil money penalty under subparagraph (A) in the same manner as they apply to a civil money penalty under that section.''.

(g) Study of AAPCC and ACR.--The Secretary of Health and Human Services shall provide, through contract with an appropriate organization, for a study of the methods by which--

(1) the adjusted average per capita cost (``AAPCC'', as defined in section 1876(a)(4) of the Social Security Act) can be refined to more accurately reflect the average cost of providing care to different classes of patients, and

(2) the adjusted community rate (``ACR'', as defined in section 1876(e)(3) of such Act) can be refined.

The Secretary shall submit to Congress, by not later than January 1, 1988, specific legislative recommendations concerning methods by which the calculation of the AAPCC and the ACR can be refined.

(h) Allowing Medicare Beneficiaries to Disenroll at a Local Social Security Office.--The Secretary of Health and Human Services shall provide that individuals enrolled with an eligible organization under section 1876 of the Social Security Act may disenroll, on and after June 1, 1987, at any local office of the Social Security Administration.

SEC. 10223. PROVISIONS RELATING TO IMPROVEMENT OF QUALITY OF CARE.

(a) PROVIDER REPRESENTATION OF BENEFICIARIES ON APPEALS AND PERMITTING APPEAL OF CERTAIN TECHNICAL DENIALS.--

(1) PERMITTING PROVIDER REPRESENTATION OF BENEFICIARIES.--Section 1869(b)(1) of the Social Security Act (42 U.S.C. 1395ff(b)(1)) is amended by adding at the end the following: ``Sections 206(a), 1102, and 1871 shall not be construed as authorizing the Secretary to prohibit an individual from being represented under this subsection by a person that furnishes or supplies the individual, directly or indirectly, with services or items solely on the basis that the person furnishes or supplies the individual with such a service or item. Such a person cannot represent a beneficiary with respect to the issue described in section 1879(a)(2) unless the person has waived any rights for payment from the beneficiary with respect to the services or items involved in the appeal.''.

(2) PERMITTING REVIEW OF TECHNICAL DENIALS.--Section 1869 of such Act is further amended--

(A) in subsection (a), by inserting ``, the amount of benefits with respect to home health services under part B, and any other determination with respect to a claim for benefits under part A'' after ``part A,'', and

(B) in subsection (b)(1)--

(i) by striking ``or'' at the end of subparagraph (B),

(ii) by inserting ``, or'' at the end of subparagraph (C), and

(iii) by inserting after subparagraph (C) the following new subparagraph:

``(D) any other denial (other than under part B of title XI) of a claim for benefits under part A or a claim for benefits with respect to home health services under part B,''.

(3) EFFECTIVE DATE.--The amendments made by this subsection take effect on the date of the enactment of this Act.

(b) PROHIBITION OF CERTAIN PHYSICIAN INCENTIVE PLANS.--

(1) MAKING CERTAIN PLANS SUBJECT TO CIVIL MONETARY PENALTIES.--Section 1128A of the Social Security Act (42 U.S.C. 1320a-7a) is amended--

(A) by striking ``subsection (a)'' each place it appears and inserting ``subsection (a) or (b)'',

(B) in subsection (a)(1), by striking ``(h)(1)'' and ``(h)(2)'' and inserting ``(i)(1)'' and ``(i)(2)'', respectively,

(C) in subsection (f), by striking ``subsection (d)'' and inserting ``subsection (e)'',

(D) by redesignating subsections (b) through (h) as subsections (c) through (i), respectively, and

(E) by inserting after subsection (a) the following new subsection:

``(b)(1) If a hospital or an eligible organization with a risk-sharing contract under section 1876 knowingly makes a payment, directly or indirectly, to a physician as an inducement to reduce or limit services provided with respect to individuals who--

``(A) are entitled to benefits under part A or part B of title XVIII,

``(B) in the case of an eligible organization, are enrolled with the organization, and

``(C) are under the direct care of the physician,

the hospital or organization shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $2,000 for each such individual with respect to whom the payment is made.

``(2) Any physician who knowingly accepts receipt of a payment described in paragraph (1) shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $2,000 for individual described in such paragraph with respect to whom the payment is made.''

(2) EFFECTIVE DATE.--The amendments made by paragraph (1) shall apply to--

(A) payments by hospitals occurring more than 6 months after the date of the enactment of this Act, and

(B) payments by eligible organizations occurring on or after January 1, 1988.

(3) STUDY.--The Secretary of Health and Human Services shall report to Congress, not later than April 1, 1987, concerning incentive arrangements offered by health maintenance organizations and competitive medical plans to physicians. The report shall--

(A) review the type of incentive arrangements in common use,

(B) evaluate their potential to pressure improperly physicians to reduce or limit services in a medically inappropriate manner, and

(C) make recommendations concerning providing for an exception, to the prohibition contained in section 1128A(b) of the Social Security Act, for incentive arrangements that may be used by such organizations and plans to encourage efficiency in the utilization of medical and other services but that do not have a substantial potential for adverse effect on quality.

(d) STUDY TO DEVELOP A STRATEGY FOR QUALITY REVIEW AND

ASSURANCE.--

(1) IN GENERAL.--The Secretary of Health and Human Services shall arrange for a study to serve as the basis for establishing a strategy for reviewing and assuring the quality of care for which payment may be made under title XVIII of the Social Security Act.

(2) ITEMS INCLUDED IN STUDY.--Among other items, the study shall--

(A) identify the appropriate considerations which should be used in defining ``quality of care'';

(B) evaluate the relative roles of structure, process, and outcome standards in assuring quality of care;

(C) consider whether criteria and standards for defining and measuring quality of care should be developed and, if so, how this should be done;

(D) evaluate the adequacy and focus of the current methods for measuring, reviewing, and assuring quality of care;

(E) evaluate the current research on methodologies for measuring quality of care, and suggest areas of research needed for further progress;

(F) evaluate the adequacy and range of methods available to correct or prevent identified problems with quality of care;

(G) review mechanisms available for coordinating and supervising at the national level quality review and assurance activities; and

(H) develop general criteria which may be used in establishing priorities in the allocation of funds and personnel in reviewing and assuring quality of care.

(3) REPORT.--The Secretary shall submit to Congress, not later than 2 years after the date of the enactment of this Act, a report on the study. Such report shall address the items described in paragraph (2) and shall include recommendations with respect to strengthening quality assurance and review activities for services furnished under the medicare program.

(4) ARRANGEMENTS FOR STUDY.--(A) The Secretary shall request the National Academy of Sciences, acting through appropriate units, to submit an application to conduct the study described in this subsection. If the Academy submits an acceptable application, the Secretary shall enter into an appropriate arrangement with the Academy for the conduct of the study. If the Academy does not submit an acceptable application to conduct the study, the Secretary may request one or more appropriate nonprofit private entities to submit an application to conduct the study and may enter into an appropriate arrangement for the conduct of the study by the

entity which submits the best acceptable application.

(B) In developing plans for the conduct of the study, the Secretary shall assure that consumer and provider groups, peer review organizations, the Joint Commission on Accreditation of Hospitals, professional societies, and private purchasers of care with experience and expertise in the monitoring of the quality of care are consulted.

SEC. 10224. TECHNICAL AMENDMENTS AND MISCELLANEOUS PROVSIIONS RELATING TO PARTS A AND B.

(a) TREATMENT OF GROUP PURCHASING VENDOR AGREEMENTS.--

(1) IN GENERAL.--Section 1877(b)(3) of the Social Security Act (42 U.S.C. 1395nn(b)(3)) is amended--

(A) by striking ``and'' at the end of subparagraph (A),

(B) by striking the period at the end of subparagraph (B) and inserting ``; and'', and

(C) by adding at the end the following:

``(C) any amount paid by a vendor of goods or services to a person authorized to act as a purchasing agent for a group of providers of services if--

``(i) the person has a written contract, with each such vendor and each such provider of services, which specifies the amount to be paid the person, which amount may be a fixed amount or a fixed percentage (not to exceed 3 percent) of the value of the purchases made by each such provider under the contract, and

``(ii) the person discloses to each such provider of services the amount received from each such vendor with respect to purchases made by or on behalf of the provider.''.

(2) EFFECTIVE DATE.--The amendments made by paragraph (1) apply to payments made before, on, or after the date of the enactment of this Act.

(b) EXTENSION AND CLARIFICATION OF COMPETITIVE CONTRACTING AUTHORITY.--Section 2326(a) of the Deficit Reduction Act of 1984 is amended--

(1) by striking ``of the fiscal years 1985 and 1986'' and inserting ``fiscal year (beginning with fiscal year 1985 and ending with fiscal year 1989)'', and

(2) by inserting ``or fixed price'' after ``competitive bidding'' each place it appears.

(c) COBRA TECHNICAL CORRECTIONS.--

(1) CORRECTION CONCERNING TRANSITION PERIOD FOR FOREIGN MEDICAL GRADUATES IN DETERMINING PAYMENTS FOR DIRECT GRADUATE MEDICAL EDUCATION COSTS.--The matter in section 1886(h)(4)(E)(ii) of the Social Security Act (42 U.S.C. 1395ww(h)(4)(E)(ii)), added by 9202(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (in this section referred to as ``COBRA''), preceding subclause (I) is amended

by inserting ``but before July 1, 1987,'' after ``1986,''.

(2) ANNOUNCEMENT, RATHER THAN PUBLICATION, OF HMO AND CMP PAYMENT RATES.--(A) The matter in section 1876(a)(1)(A) of the Social Security Act (42 U.S.C. 1395mm(a)(1)(A)) preceding clause (i), as amended by section 9211(d) of COBRA, is amended by striking ``publish'' and inserting ``announce (in a manner intended to provide notice to interested parties)''.

(B) The amendment made by subparagraph (A) shall apply to determinations of per capita payment rates for 1987 and subsequent years.

(3) PENALTIES FOR BILLING FOR ASSISTANTS AT SURGERY FOR CERTAIN CATARACT OPERATIONS.--(A) Section 1842(k) of the Social Security Act (42 U.S.C. 1395u(k)), added by section 9307(c) of COBRA, is amended by inserting ``presents or causes to be presented a claim or'' after ``willfully'' each place it appears.

(B) The amendment made by subparagraph (A) shall apply to claims presented after the date of the enactment of this Act.

(4) TEMPORARY USE OF CARRIER PRE-PAYMENT SCREENING AS A SUBSTITUTE FOR PRE-PROCEDURE REVIEW.--For purposes of section 1862(a)(15) of the Social Security Act (42 U.S.C. 1395y(a)(15)), added by section 9307(a)(3) of COBRA, and for surgical procedures performed during the period beginning on April 1, 1986, and ending on December 15, 1986, a carrier is deemed to have approved the use of an assistant in a surgical procedure, before the surgery is performed, based on the existence of a complicating medical condition if the carrier determines after the surgery is performed that the use of the assistant in the procedure was appropriate based on the existence of a complicating medical condition before or during the surgery.

(5) EXTENSION OF CONTINUATION PERIOD OF ACCESS: MEDICARE DEMONSTRATION PROJECT.--Section 9221(a) of COBRA is amended by striking ``September 30, 1986'' and inserting ``July 31, 1987''.

(6) MISCELLANEOUS PROVISIONS.--(A) Section 9127(b) of COBRA is amended by inserting ``, except that the Director may provide initially for such terms as will insure that (on a continuing basis) the terms of no more than eight members will expire in any one year'' after ``years''.

(B) Section 9202(j) of COBRA is amended by inserting ``or section 402 of the Social Security Amendments of 1967'' after ``section 1886(c) of the Social Security Act''.

(C) Section 1842(h) of the Social Security Act (42 U.S.C. 1395u(h)), as amended by section 9301(c) of COBRA, is amended--

(i) in paragraph (5), as redesignated by section 9301(c)(3)(D) of COBRA, by striking ``such'' each place it appears, and

(ii) in paragraph (6), as so redesignated, by striking ``the the'' and inserting ``the''.

(D) Section 9301(c)(5) of COBRA is amended by striking ``1842(b)(7)'' and inserting ``1842(h)(7)''.

(E) Section 1842(b)(8) of the Social Security Act, as added by section 9304(a) of COBRA, is amended--

(i) in subparagraph (A), by inserting ``by carriers'' after ``to be used'', and

(ii) in subparagraph (B), by inserting ``by carriers'' after ``be considered''.

(F) The amendments made by this paragraph are effective as if they had been included in the enactment of COBRA.

PART 3--PROVISIONS RELATING TO MEDICARE PART B

SEC. 10231. EXTENSION OF PREMIUM PAYMENT PROVISION THROUGH 1989.

Section 1839 of the Social Security Act (42 U.S.C. 1395r) is amended--

(1) in subsection (e), by striking ``1989'' and inserting ``1990'' each place it appears;

(2) in subsection (f)(1), by striking ``or 1987'' and inserting ``, 1987, or 1988''; and

(3) in subsection (f)(2), by striking ``or 1988'' and inserting ``, 1988, or 1989''.

SEC. 10232. PAYMENT FOR PHYSICIANS' SERVICES, RESTRICTIONS ON REASONABLE CHARGE LIMITATIONS, AND INCENTIVES FOR PHYSICIAN PARTICIPATION.

(a) DETERMINATION OF MAXIMUM ALLOWABLE PREVAILING CHARGES FOR PHYSICIANS' SERVICES.--

(1) IN GENERAL.--Section 1842(b)(4)(A) of the Social Security Act (42 U.S.C. 1395u(b)(4)(A)) is amended by striking clause (iii) and inserting the following:

``(iii) In determining the maximum allowable prevailing charges which may be recognized consistent with the index described in fourth sentence of paragraph (3) for physicians' services furnished on or after January 1, 1987, by participating and nonparticipating physicians, respectively, the Secretary shall treat the maximum allowable prevailing charges recognized as of December 31, 1986, under such sentence with respect to participating and nonparticipating physicians, respectively, as having been justified by economic changes.

``(iv) Beginning with 1987, the percentage increase in the MEI (as defined in subparagraph (E)(ii)) shall be the same for nonparticipating physicians as for participating physicians.''.

(2) CONFORMING AMENDMENT.--Section 1842(b)(4)(C) of such Act is amended--

(A) by striking ``(i)'' after ``(C)'', and

(B) by striking clause (ii).

(3) DEFINITIONS.--Section 1842(b)(4) of such Act is further amended by adding at the end the following new subparagraph:

``(E) In this section:

``(i) The term `participating physician' refers, with respect to the furnishing of services, to a physician who at the time of furnishing the services is a participating physician (under subsection (h)(1)), and the term `nonparticipating physician' refers, with respect to the furnishing of services, a physician who at the time of furnishing the services is not a participating physician.

``(ii) The term `percentage increase in the MEI' means, with respect to physicians' services furnished in a year, the percentage increase in the medicare economic index (referred to in the fourth sentence of paragraph (3)) applicable to such services furnished as of the first day of that year.''.

(4) EFFECTIVE DATE.--The amendments made by this subsection shall apply to services furnished on or after January 1, 1987.

(b) 1 PERCENT BONUS FOR PARTICIPATING PHYSICIANS.--Section 1842(b)(4)(A)(ii) of such Act is amended by adding at the end the following new subclause:

``(III) In applying the percentage increase in the MEI for physicians' services furnished by a participating physician during each year after 1986, the Secretary shall provide a bonus of 1 percentage point in the percentage increase otherwise determined. Such a bonus for each year shall apply to physicians' services furnished only during the year and not in the calculation of payments for any subsequent year.''.

(c) LIMIT ON ACTUAL CHARGES FOR NONPARTICIPATING PHYSICIANS.--

(1) IN GENERAL.--Section 1842(j)(1) of such Act is amended--

(A) by inserting ``(A)'' after ``(j)(1)'', and

(B) by adding at the end the following new subparagraph:

``(B) During any period, on or after January 1, 1987, during which a physician is a nonparticipating physician, the Secretary shall monitor each such physician's actual charges for physicians' services furnished to individuals enrolled under this part. If such physician knowingly and willfully bills for such services actual charges in excess of the charges permitted under subparagraph (C), the Secretary may apply sanctions against such physician in accordance with paragraph (2).

``(C) For physicians' services furnished by a physician to individuals enrolled under this part--

``(i) during 1987, in the case of such services for which the physician--

``(I) has actual charges for the calendar quarter beginning on April 1, 1984, the limit is the physician's actual charges for such services furnished during such quarter increased by the sum of the percentage increase in the MEI (as defined in subsection (b)(4)(E)) for 1987 and 1 percentage point, or

(II) has no actual charges for such calendar quarter, the limit is the 50th percentile of the customary charges (weighted by frequency of procedure) for the procedure performed by nonparticipating physicians in the locality during the 12-month period ending June 30, 1986, increased by the sum of the percentage increase in the MEI for 1987 and 1 percentage point; and

(ii) during a subsequent year, the limit is the maximum actual charges permitted under this subparagraph for the previous year increased by the percentage increase in the MEI for that subequent year.''.

(2) PROVISION OF ACTUAL CHARGE INFORMATION BY CARRIER TO NONPARTICIPATING PHYSICIANS.--Section 1842(b)(3) of such Act is amended--

(A) by striking ``and'' at the end of subparagraph (E),

(B) by inserting ``and'' at the end of subparagraph (F), and

(C) by inserting after subparagraph (F) the following new subparagraph:

``(G) will provide such information to nonparticipating physicians as is available to enable the physicians to determine the maximum actual charges permitted under subsection (j)(1)(C);''.

(3) CONFORMING AMENDMENT.--Section 1842(b)(4)(D) is amended by adding at the end the following new clause:

``(iv) In determining the customary charges for physicians' services furnished on or after January 1, 1988, if a physician was a nonparticipating physician in a previous year (beginning with 1987), the Secretary shall not recognize any amount of such charges for services furnished during such previous year that exceeds the limit on actual charges imposed under subsection (j)(1)(C).''.

(4) EFFECTIVE DATE.--The amendments made by this subsection shall apply to services furnished on or after January 1, 1987.

(d) PROHIBITING RETROACTIVE ADJUSTMENT OF MEDICARE ECONOMIC INDEX.--The Secretary of Health and Human Services is not authorized to revise the economic index referred to in the fourth sentence of section 1842(b)(3) of the Social Security Act in a manner that provides, for any period before January 1, 1985, for the substitution of a rental equivalence or rental substitution factor for the housing component of the consumer price index.

(e) RESTRICTIONS ON REASONABLE CHARGE LIMITATIONS.--

(1) IN GENERAL.--Section 1842(b)(8) of the Social Security Act (42 U.S.C. 1395u(b)(8)) is amended by adding at the end the following: ``In the case of items and services other than physicians' services, a carrier shall only provide, in the process of calculating the prevailing charge for specific items and services, for not considering charges in specific instances in which the charges, in comparison with the charges for similar items and services, are grossly excessive or deficient. Nothing in this paragraph or this Act shall be construed as authorizing the Secretary, through regulations, guidelines, instructions, or otherwise, to require carriers to reduce payment amounts under this part for specific items and services for which the Secretary has made a specific determination that the payment amounts or charges are excessive.''.

(2) SUBMISSION OF RECOMMENDATIONS TO CONGRESS.--The Secretary of Health and Human Services, after consultation with the Physician Payment Review Commission, shall submit to Congress, by not later than April 1, 1987, recommendations concerning payment reductions under part B of title XVIII of the Social Security Act for overpriced items and services. Such recommendations shall include the specific payment reductions recommended and measures to assure that such reductions in payment do not result in corresponding increases in out-of-pocket costs to medicare beneficiaries.

(f) RECRUITING.--

(1) CARRIER RESPONSIBILITY.--Section 1842(b)(3) of such Act, as amended by subsection (c)(2), is further amended--

(A) by striking ``and'' at the end of subparagraph (F),

(B) by inserting ``and'' at the end of subparagraph (G), and

(C) by inserting after subparagraph (G) the following new subparagraph:

``(H) if it makes determinations or payments with respect to physicians' services, will implement--

(i) programs to recruit and retain physicians as participating physicians in the area served by the carrier, including educational and outreach activities and the use of professional relations personnel to handle billing and other problems relating to payment of claims of participating physicians; and

(ii) programs to familiarize beneficiaries with the participating physician program and to assist such beneficiaries in locating participating physicians;''.

(2) MEASURING CARRIER PERFORMANCE.--The Secretary of Health and Human Services shall provide, in the standards and

criteria established under section 1842(b)(2) of the Social Security Act for contracts under that section, a system to measure a carrier's performance of the responsibilities described in sections 1842(b)(3)(H) and 1842(h) of such Act.

(3) CARRIER BONUSES FOR GOOD PERFORMANCE.--Of the amounts appropriated for administrative activities to carry out part B of title XVIII of the Social Security Act, the Secretary of Health and Human Services shall provide payments, totaling 1 percent of the total payments to carriers for claims processing in any fiscal year, to carriers under section 1842 of such Act, to reward such carriers for their success in increasing the proportion of physicians in the carrier's service area who are participating physicians.

(4) EFFECTIVE DATES.--

(A) CARRIER RESPONSIBILITY.--The amendment made by paragraph (1) shall be effective for contracts under section 1842 of the Social Security Act as of October 1, 1987.

(B) PERFORMANCE MEASURES.--The Secretary of Health and Human Services shall provide for the establishment of the standards and criteria required under paragraph (2) by not later than October 1, 1987, which shall apply to contracts as of October 1, 1987.

(C) CARRIER BONUSES.--From the amounts appropriated for each fiscal year (beginning with fiscal year 1988), the Secretary of Health and Human Services shall first provide for payments of bonuses to carriers under paragraph (3) not later than April 1, 1988, to reflect performance of carriers during November 1987.

(g) DIRECTORIES OF PARTICIPATING PHYSILIANS.--

(1) REQUIRING DISTRIBUTION TO MEDICARE BENEFICIARIES.--Section 1842(h)(6) of the Social Security Act (42 U.S.C. 1395u(h)(6)) is amended--

(A) in the second sentence--

(i) by inserting after ``that area'' the following: ``and to each individual enrolled under this part and residing in that area'', and

(ii) by inserting before the period the following: ``and that an appropriate number of copies of each such directory is sent to hospitals located in the area''; and

(B) by adding at the end the following: ``Such copies shall be sent free of charge.''.

(2) ORGANIZATION OF DIRECTORIES.--Section 1842(h)(4) of such Act is amended by adding at the end the following: ``Each participating physician directory for an area shall provide an alphabetical listing of all participating physicians practicing in the area and an alphabetical listing by locality and specialty of such physicians.''.

(3) PERIOD FOR PHYSICIAN ENROLLMENT.--Section 1842(h)(1) of such Act is amended by striking ``the beginning of any year beginning with 1984'' and inserting ``during the month of November before a year''.

(4) EFFECTIVE DATES.--

(A) DISTRIBUTION AND ORGANIZATION.--The amendment made by--

(i) paragraph (1)(A)(i) shall first apply to directories for 1988,

(ii) paragraph (1)(A)(ii) shall first apply to directories for 1987, and

(iii) paragraph (1)(B) takes effect on the date of the enactment of this Act.

(B) ENROLLMENT PERIOD.--The amendment made by paragraph (3) shall apply to participation agreements entered into for 1988 and subsequent years.

(h) PROHIBITING UNASSIGNED BILLING OF SERVICES DETERMINED TO BE MEDICALLY UNNECESSARY BY A CARRIER.--

(1) IN GENERAL.--Section 1842 of the Social Security Act is further amended by adding at the end the following new subsection:

``(l)(1)(A) Subject to subparagraph (C), if--

``(i) a nonparticipating physician furnishes services to an individual enrolled for benefits under this part,

``(ii) payment for such services is not accepted on an assignment-related basis,

``(iii) a carrier determines under this part or a peer review organization determines under part B of title XI that payment may not be made by reason of section 1862(a)(1), and

``(iv) the physician has collected any amounts for such services,

the physician shall refund on a timely basis to the individual (and shall be liable to the individual for) any amounts so collected.

``(B) A refund under subparagraph (A) is considered to be on a timely basis only if--

``(i) in the case of a physician who does not request reconsideration or seek appeal on a timely basis, the refund is made within 30 days after the date the physician receives a denial notice under paragraph (2), or

``(ii) in the case in which such a reconsideration or appeal is taken, the refund is made within 15 days after the date the physician receives notice of an adverse determination on reconsideration or appeal.

``(C) Subparagraph (A) shall not apply to the furnishing of a service by a physician to an individual if--

``(i) the physician did not know and could not reasonably have been expected to know that payment may not be made for the service by reason of section 1862(a)(1), or ``(ii) before the service was provided, the individual was informed that payment under this part may not be made for the specific service and the individual has agreed to pay for that service.

``(2) Each carrier with a contract in effect under this section with respect to physicians and each peer review organization with a contract under part B of title XI shall send any notice of denial of payment for physicians' services based on section 1862(a)(1) and for which payment is not requested on an assignment-related basis to the physician and the individual involved.

``(3) If a physician knowingly and willfully fails to make refunds in violation of paragraph (1)(A), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2).''.

(2) CONFORMING AMENDMENT.--Section 1842(j)(2) of such Act is amended by inserting ``or (l)'' after ``(k)''.

(3) EFFECTIVE DATE.--The amendments made by this subsection shall apply to services furnished on or after October 1, 1987.

(i) MAINTENANCE AND USE OF PARTICIPATING PHYSICIAN DIRECTORIES BY HOSPITALS.--

(1) REQUIREMENT OF PARTICIPATION.--Section 1866(a) of the Social Security Act, as amended by sections 10207(e)(6)(A) and 10205(b)(1) of this subtitle, is further amended--

(A) by striking ``and'' at the end of subparagraph (K),

(B) by striking the period at the end of subparagraph (L) and inserting ``, and'', and

(C) by inserting after subparagraph (L) the following new subparagraph:

``(M) in the case of hospitals--

(i) to make available to its patients the directory or directories of participating physicians (published under section 1842(h)(4)) for the area served by the hospital, and

(ii) if hospital personnel (including staff of any emergency or outpatient department) refer a patient to a nonparticipating physician for further medical care on an outpatient basis, the personnel must inform the patient that the physician is a nonparticipating physician and, whenever practicable, must identify at least one qualified participating physician who is listed in such a directory and from whom the patient may receive the necessary services.''.

(2) EFFECTIVE DATE.--The amendment made by paragraph (1) shall apply to agreements under section 1866(a) of the Social Security Act as of October 1, 1987.

(j) DISCLOSURE OF INFORMATION OF UNASSIGNED CLAIMS FOR

CERTAIN PHYSICIANS' SERVICES.--

(1) IN GENERAL.--Section 1842 of the Social Security Act, as amended by subsection (h)(1), is further amended by adding at the end the following new subsection:

``(m)(1) In the case of a nonparticipating physician who--

(A) performs an elective surgical procedure for an individual enrolled for benefits under this part and for which the physician's actual charge is at least $500, and

``(B) does not accept payment for such procedure on an assignment-related basis,

the physician must disclose to the individual, in writing and in a form approved by the Secretary, the physician's estimated actual charge for the procedure, the estimated approved charge under this part for the procedure, and the excess of the physician's actual charge over the approved charge.

``(2) A physician who fails to make a disclosure required under paragraph (1) with respect to a procedure shall refund on a timely basis to the individual (and shall be liable to the individual for) any amounts collected for the procedure in excess of the charges recognized and approved under this part.

``(3) If a physician knowingly and willfully fails to comply with paragraph (2), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2).

``(4) The Secretary shall provide for such monitoring of requests for payment for physicians' services to which paragraph (1) applies as is necessary to assure compliance with paragraph (2).''.

(2) CONFORMING AMENDMENT.--Section 1842(j)(2) of such Act, as amended by subsection (h)(2) of this section, is amended by striking ``or (1)'' and inserting ``, (1), or (m)''.

(3) EFFECTIVE DATE.--The amendments made by this subsection shall apply to surgical procedures performed on or after October 1, 1987.

SEC. 10233. PAYMENT RATES FOR RENAL SERVICES AND IMPROVEMENTS IN ADMINISTRATION OF END STAGE RENAL DISEASE NETWORKS AND PROGRAM.

(a) COMPOSITE RATES FOR DIALYSIS TREATMENT.--

(1) IN GENERAL.--The Secretary of Health and Human Services may provide for an adjustment of the composite rates established under section 1881(b)(7) of the Social Security Act, but only if the base rate for routine dialysis treatment in a free-standing facility is not less than $117.50, and only if the base rate for routine dialysis treatment in a hospital-based facility is not less than $121.50.

(2) ASSURING PROMPT CONSIDERATION OF EXCEPTION REQUESTS.--Section 1881(b)(7) of the Social Security Act (42 U.S.C. 1395rr(b)(7)) is amended by inserting after the third sentence the following new sentence: ``Each application for

such an exception for a sole facility located in an isolated, rural area shall be deemed to be approved as of the date of its filing unless the Secretary disapproves it by not later than 45 working days after the date the application is filed.''.

(3) EFFECTIVE DATE.--(A) Paragraph (1) shall apply to dialysis treatment furnished on or after October 1, 1986.

(B) The amendment made by paragraph (2) shall apply to applications filed on or after October 1, 1986.

(b) PAYMENT FOR PHYSICIANS' SERVICES.--In establishing the payment rates, under section 1881(b)(3)(B) of the Social Security Act, for physicians' services furnished on or after August 1, 1986, to individuals determined to have end stage renal disease, the Secretary of Health and Human Services shall provide for an adjustment in the home/facility physician treatment capability ratio (used in establishing such payment rates) to 3.9 to 1 in order to reduce by $14.81 the current average monthly capitation rate for physicians's services to outpatient maintenance dialysis patients (based on a weighted average by State ESRD population).

(c) REPORT ON PAYMENT RATES.--

(1) IN GENERAL.--The Secretary of Health and Human Services shall provide for--

(A) a study to evaluate the effects of reductions in the rates of payment for facility and physicians' services under the medicare program for patients with end stage renal disease on their access to care or on the quality of care, and

(B) a report to Congress on the results of the study by not later than January 1, 1988.

(2) ARRANGEMENTS WITH INSTITUTE OF MEDICINE.--The Secretary shall request the National Academy of Sciences, acting through appropriate units, to submit an application to conduct the study described in paragraph (1). If the Academy submits an acceptable application, the Secretary shall enter into an appropriate arrangement with the Academy for the conduct of the study. If the Academy does not submit an acceptable application to conduct the study, the Secretary may request one or more appropriate nonprofit private entities to submit an application to conduct the study and may enter into an appropriate arrangement for the conduct of the study by the entity which submits the best acceptable application.

(d) REORGANIZATION OF ESRD NETWORK AREAS AND ORGANIZATIONS.--

(1) IN GENERAL.--Subparagraph (A) of subsection (c)(1) of section 1881 of the Social Security Act (42 U.S.C. 1395rr) is amended to read as follows:

``(A)(i) For the purpose of assuring effective and efficient administration of the benefits provided under this section, the Secretary shall, in accordance with such criteria as he finds necessary to assure the performance of the responsibilities and functions specified in paragraph (2)--

``(I) establish at least 17 end stage renal disease network areas, and

``(II) for each such area, designate a network administrative organization which, in accordance with regulations of the Secretary, shall establish (aa) a network council of renal dialysis and transplant facilities located in the area and (bb) a medical review board, which has a membership including at least one patient representative and physicians, nurses, and social workers engaged in treatment relating to end stage renal disease.

The Secretary shall publish in the Federal Register a description of the geographic area that he determines, after consultation with appropriate professional and patient organizations, constitutes each network area and the criteria on the basis of which such determination is made.

``(ii)(I) In order to determine whether the Secretary should enter into, continue, or terminate an agreement with a network administrative organization designated for an area established under clause (i), the Secretary shall develop and publish in the Federal Register standards, criteria, and procedures to evaluate an applicant organization's capabilities to perform (and, in the case of an organization with which such an agreement is in effect, actual performance of) the responsibilities described in paragraph (2).

``(II) An agreement with a network administrative organization may be terminated by the Secretary only if he finds, after applying such standards and criteria, that the organization has failed to perform its prescribed responsibilities effectively and efficiently. If such an agreement is to be terminated, the Secretary shall select a successor to the agreement on the basis of competitive bidding and in a manner that provides an orderly transition.''.

(2) DEADLINE FOR ESTABLISHING NEW AREAS.--The Secretary of Health and Human Services shall establish end stage renal disease network areas, pursuant to the amendment made by paragraph (1), not later than January 1, 1987.

(3) SPECIAL TREATMENT OF EXISTING NETWORK ORGANIZATIONS.--In first designating network administrative organizations for areas so established, the Secretary shall designate the network organization (or a voluntary combination of such organizations) in operation on the date of the enactment of this Act as the network administrative organization, unless the Secretary determines that such organizations do not meet minimal standards and criteria established under section 1881(c)(1)(A)(ii) of the Social Security Act (as amended by paragraph (1)).

(e) PATIENT REPRESENTATION ON COUNCILS AND MEDICAL REVIEW

BOARDS.--Subparagraph (B) of subsection (c)(1) of section 1881 of the Social Security Act is amended to read as follows:

``(B) At least one patient representative shall serve as a member of each network council and each medical review board.''.

(f) RESPONSIBILTIES OF NETWORK ORGANIZATIONS.--Subsection (c)(2) of section 1881 of such Act is amended--

(1) in subparagraph (A), by inserting before the semicolon the following: ``and the participation of patients, providers of services, and renal disease facilities in vocational rehabilitation programs'';

(2) in subparagraph (B), by inserting before the first semicolon the following: ``and with respect to working with patients, facilities, and providers in encouraging participation in vocational rehabilitation programs'';

(3) in subparagraph (D), by inserting before the semicolon the following: ``and reporting to the Secretary on facilities and providers that are not providing appropriate medical care'';

(4) in subparagraph (E), by inserting ``and encouraging participation in vocational rehabilitation programs'' after ``self-care settings and transplantation''; and

(5) by redesignating subparagraphs (D) and (E) as subparagraphs (G) and (H), respectively, and inserting after subparagraph (C) the following new subparagraphs:

``(D) implementing a procedure for evaluating and resolving patient grievances;

``(E) conducting on-site reviews of facilities and providers as necessary (as determined by a medical review board or the Secretary), utilizing standards of care established by the network organization to assure proper medical care;

``(F) collecting, validating, and analyzing such data as are necessary to prepare the reports required by subparagraph (H) and subsection (g) and to assure the maintenance of the registry established under paragraph (7);''.

(g) FACILITY COOPERATION WITH NETWORKS.--The first sentence of subsection (c)(3) of section 1881 of such Act is amended by inserting ``or to follow the recommendations of the medical review board'' after ``consistently failed to cooperate with network plans and goals''.

(h) INTENT OF CONGRESS RESPECTING MAXIMUM USE OF VOCATIONAL REHABILITATION SERVICES.--The first sentence of subsection (c)(6) of section 1881 of such Act is amended by inserting before the period the following: ``and that the maximum practical number of patients who are suitable candidates for vocational rehabilitation services be given access to such services and encouraged to return to gainful employment''.

(i) NATIONAL END STAGE RENAL DISEASE REGISTRY.--

(1) ESTABLISHMENT OF REGISTRY.--Subsection (c) of section

1881 of such Act is further amended by adding at the end the following new paragraph:

(7) The Secretary shall establish a national end stage renal disease registry the purpose of which shall be to assemble and analyze the data reported by network organizations, transplant centers, and other sources on all end stage renal disease patients in a manner that will permit--

(A) the preparation of the annual report to the Congress required under subsection (g);

(B) an identification of the economic impact, cost-effectiveness, and medical efficacy of alternative modalities of treatment;

(C) an evaluation with respect to the most appropriate allocation of resources for the treatment and research into the cause of end stage renal disease;

(D) the determination of patient mortality and morbidity rates, and trends in such rates, and other indices of quality of care; and

(E) such other analyses relating to the treatment and management of end stage renal disease as will assist the Congress in evaluating the end stage renal disease program under this section.

The Secretary shall provide for such coordination of data collection activities, and such consolidation of existing end stage renal disease data systems, as is necessary to achieve the purpose of such registry, shall determine the appropriate location of the registry, and shall provide for the appointment of a professional advisory group to assist the Secretary in the formulation of policies and procedures relevant to the management of such registry.''.

(2) REPORT.--The Secretary of Health and Human Services shall submit to the Congress, no later than January 1, 1987, a full report on the progress made in establishing the national end stage renal disease registry under the amendment made by paragraph (1) and shall establish such registry by not later than January 1, 1988.

(j) FUNDING OF ESRD NETWORK ORGANIZATIONS.--

(1) IN GENERAL.--Subsection (b)(7) of section 1881 of the Social Security Act is amended by adding at the end the following new sentence: ``The Secretary shall reduce the amount of each composite rate payment under this paragraph for each treatment by 50 cents (subject to such adjustments as may be required to reflect modes of dialysis other than hemodialysis) and provide for payment of such amount to the network administrative organization (designated under subsection (c)(1)(A) for the network area in which the treatment is provided) for its necessary and proper administrative costs incurred in carrying out its responsibilities under subsection (c)(2).''.

(2) EFFECTIVE DATE.--The amendment made by paragraph (1) shall apply to treatment furnished on or after January 1, 1987.

(k) PROTOCOLS ON REUSE OF DIALYSIS FILTERS AND OTHER DIALYSIS SUPPLIES.--

(1) ESTABLISHMENT OF PROTOCOLS.--Paragraph (7) of subsection (f) of section 1881 of the Social Security Act is amended to read as follows:

``(7)(A) The Secretary shall establish protocols on standards and conditions for the reuse of dialyzer filters for those facilities and providers which voluntarily elect to reuse such filters.

``(B) The Secretary shall study and review the appropriateness of establishing protocols on standards and conditions for the reuse (where appropriate) of other dialysis supplies (such as blood lines, transducer filters, and dialyzer caps). If the Secretary determines that the establishment of such a protocol with respect to any such dialysis supplies is appropriate, the Secretary may establish such a protocol.

``(C) The Secretary shall incorporate protocols established under this paragraph into the requirements for facilities prescribed under subsection (b)(1)(A) and failure to follow such a protocol subjects such a facility to denial of participation in the program established under this section and to denial of payment for dialysis treatment not furnished in compliance with such a protocol.''.

(2) DEADLINE AND REPORT.--The Secretary of Health and Human Services--

(A) shall establish the protocols described in section 1881(f)(7)(A) of the Social Security Act by not later than January 1, 1988, and

(B) shall report to the Congress, not later than January 1, 1988, on the study and review conducted under section 1881(f)(7)(B) of such Act.

(l) EFFECTIVE DATE FOR CERTAIN AMENDMENTS.--The amendments made by subsections (e), (f), and (g) shall apply to network administrative organizations designated for network areas established under the amendment made by subsection (d)(1).

SEC. 10234. TECHNICAL AMENDMENTS AND MISCELLANEOUS PROVISIONS RELATING TO PART B.

(a) ADDITIONAL MEMBERS FOR PHYSICIAN PAYMENT REVIEW COMMISSION.--

(1) 2 ADDITIONAL MEMBERS.--Section 1845(a)(2) of the Social Security Act (42 U.S.C. 1395w-1(a)(2)) is amended by striking ``11 individuals'' and inserting ``13 individuals''.

(2) APPOINTMENT OF ADDITIONAL MEMBERS.--The Director of the Congressional Office of Technology Assessment shall appoint the two additional members of the Physician Payment Review Commission, as required by the amendment made by

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paragraph (1), no later than 60 days after the date of the enactment of this Act, for terms of 3 years, except that the Director may provide initially for such terms as will insure that (on a continuing basis) the terms of no more than five members expire in any one year.

(b) EFFECTIVE DATE OF VOLUNTARY DISENROLLMENT FROM MEDICARE.--

(1) IN GENERAL.--The second and sixth sentences of section 1838(b) of the Social Security Act (42 U.S.C. 1395p(b)) are each amended by striking ``following the calendar quarter''.

(2) EFFECTIVE DATE.--The amendments made by paragraph (1) shall apply to notices filed on or after October 1, 1986.

(c) STUDY ON PROSPECTIVE PAYMENT OF RADIOLOGY, ANESTHESIA, AND PATHOLOGY SERVICES TO HOSPITAL INPATIENTS.--The Secretary of Health and Human Services shall study and report to the Committee on Ways and Means of the House of Representatives, by April 1, 1987, concerning the design and implementation of a prospective payment system for payment, under part B of title XVIII of the Social Security, for radiology, anesthesia, and pathology services furnished to hospital inpatients. Such report shall include data, from a representative sample, showing, for discharges classified within each diagnosis-related group, the distribution of total reasonable charges and costs for each inpatient discharge for such services.

PART 4--IMPROVED REVIEW OF QUALITY BY PEER REVIEW ORGANIZATIONS

SEC. 10241. IMPROVED REVIEW OF QUALITY BY PEER REVIEW ORGANIZATIONS.

(a) PRO REVIEW OF HOSPITAL DENIAL NOTICES.--

(1) IN GENERAL.--Section 1154 of the Social Security Act (42 U.S.C. 1320c-3) is amended by adding at the end the following new subsection:

``(d)(1) If--

(A) a hospital has determined that a patient no longer requires inpatient hospital care, and

(B) the attending physician has agreed with the hospital's determination,

the hospital may provide the patient (or the patient's representative) with a notice (meeting conditions prescribed by the Secretary under section 1879) of the determination.

``(2) If--

(A) a hospital has determined that a patient no longer requires inpatient hospital care, but

(B) the attending physician has not agreed with the hospital's determination,

the hospital may request the appropriate peer review organization to review under subsection (a) the validity of the hospital's determination.

``(3)(A) If a patient (or a patient's representative)--

``(i) has received a notice under paragraph (1), and

``(ii) requests the appropriate peer review organization to review the determination,

then, the organization shall conduct a review under subsection (a) of the validity of the hospital's determination and shall provide notice (by telephone and in writing) to the patient or representative and the hospital and attending physician involved of the results of the review. Such review shall be conducted regardless of whether or not the hospital will charge for continued hospital care or whether or not the patient will be liable for payment for such continued care.

``(B) If a patient (or a patient's representative) requests a review under subparagraph (A) while the patient is still an inpatient in the hospital and not later than noon of the first working day after the date the patient receives the notice under paragraph (1), then--

``(i) the hospital shall provide to the appropriate peer review organization the records required to review the determination by the close of business of such first working day, and

``(ii) the peer review organization must provide the notice under subparagraph (A) by not later than one full working day after the date the organization has received the request and such records.

``(4) If--

``(A) a request is made under paragraph (3)(A) not later than noon of the first working day after the date the patient (or patient's representative) receives the notice under paragraph (1), and

``(B) the conditions described in section 1879(a)(2) with respect to the patient or representative are met,

the hospital may not charge the patient for inpatient hospital services furnished before noon of the day after the date the patient or representative receives notice of the peer review organization's decision.

``(5) In any review conducted under paragraph (2) or (3), the organization shall solicit the views of the patient involved (or the patient's representative).''.

(2) EFFECTIVE DATE.--(A) Except as provided in subparagraph (B), the amendment made by paragraph (1) shall apply to denial notices furnished by hospitals to individuals on or after the first day of the first month that begins more than 30 days after the date of the enactment of this Act.

(B) Section 1154(d)(4) of the Social Security Act (as added by the amendment made by paragraph (1)) shall take effect on the date of the enactment of this Act.

(b) PRO REVIEW OF INPATIENT HOSPITAL SERVICES AND EARLY

READMISSION CASES.--

(1) TIMELY PROVISION OF HOSPITAL INFORMATION.--Section 1153 of such Act (42 U.S.C. 1320c-2) is amended by adding at the end the following new subsection:

``(g) The Secretary shall provide that peer review organizations receive each month, on a timely basis, either directly from hospitals or through fiscal intermediaries data necessary to initiate the review process under section 1154(a) on a timely basis.''

(2) REQUIRING REVIEW OF EARLY READMISSION CASES.--Section 1154(a) of such Act (42 U.S.C. 1320c-3(a)), as amended by section 9401(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985, is amended by adding at the end the following new paragraph:

``(13) Notwithstanding paragraph (4), the organization shall perform the review described in paragraph (1) with respect to early readmission cases to determine if the previous inpatient hospital services and the post-hospital services met professionally recognized standards of health care. Such reviews may be performed on a sample basis if the organization and the Secretary determine it to be appropriate. In this paragraph, an `early readmission case' is a case in which an individual, after discharge from a hospital, is readmitted to a hospital less than 31 days after the date of the most recent previous discharge.''

(3) EFFECTIVE DATES.--(A) The Secretary of Health and Human Services shall implement the amendment made by paragraph (1) not later than 6 months after the date of the enactment of this Act.

(B) The amendment made by paragraph (2) shall apply to contracts entered into or renewed on or after January 1, 1987.

(c) REQUIRING PRO REVIEW OF QUALITY OF CARE.--

(1) ALLOCATION OF FUNDS FOR QUALITY CARE REVIEW.--Section 1154(a)(4) of such Act (42 U.S.C. 1320c-3(a)(4)) is amended by adding at the end the following: ``Each peer review organization shall provide that a reasonable proportion of its activities are involved with reviewing, under paragraph (1)(B), the quality of services and that a reasonable allocation of such activities relating to quality of services is made among the different cases and settings (including inpatient hospital care, post-acute-care settings, ambulatory settings, health maintenance organizations, and competitive medical plans). In establishing such allocation, the organization shall consider (i) whether there is reason to believe that there is a particular need for reviews of particular cases or settings because of previous problems regarding quality of care, (ii) the cost of such reviews and the likely yield of such reviews in terms of number and

seriousness of quality of care problems likely to be discovered as a result of such reviews, and (iii) the availability and adequacy of alternative quality review and assurance mechanisms.''.

(2) REQUIRING REVIEW OF HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS.--Such section is further amended--

(A) by inserting ``(A)'' after ``(4)'',

(B) by adding at the end the following new subparagraph:

``(B) The contract of each organization shall provide for the review of services (including both inpatient and outpatient services) provided by eligible organizations pursuant to a contract under section 1876 for the purpose of determining whether the quality of such services meets professionally recognized standards of health care, including whether appropriate health care services have not been provided or have been provided in inappropriate settings.'', and

(C) by adding at the end of such subparagraph the following: ``Under the contract the level of effort expended by the organization on reviews under this subparagraph shall be equivalent, on a per enrollee basis, to the level of effort expended by the organization on utilization and quality reviews performed with respect to individuals not enrolled with an eligible organization.''.

(3) IDENTIFICATION OF METHODS FOR IDENTIFYING CASES OF SUBSTANDARD CARE.--Section 1154 of such Act (42 U.S.C. 1320c-3), as amended by subsection (a)(1), is amended by adding at the end the following new subsection:

``(e) The Secretary, in consultation with appropriate experts, shall identify methods that would be available to assist peer review organizations (under subsection (a)(4)) in identifying those cases which are more likely than others to be associated with a quality of services which does not meet professionally recognized standards of health care.''

(4) EFFECTIVE DATES.--(A) The amendments made by paragraphs (1) and (2)(B) shall apply to contracts as of January 1, 1987.

(B) The amendment made by paragraph (2)(C) shall apply to review activities conducted by organizations on or after January 1, 1988.

(C) The amendment made by the paragraph (3) becomes effective on the date of the enactment of this Act.

(d) REQUIRING CONSUMER REPRESENTATIVE ON PEER REVIEW BOARDS.--

(1) IN GENERAL.--Section 1152 of such Act (42 U.S.C. 1320c-1) is amended--

(A) by striking ``and'' at the end of paragraph (1),

(B) by striking the period at the end of paragraph (2) and inserting ``; and'', and

(C) by adding at the end the following new paragraph:

``(3) has at least one individual who is a representative of consumers on its board of directors.''

(2) EFFECTIVE DATE.--The amendment made by paragraph (1) shall apply to contracts entered into or renewed on or after January 1, 1987.

(e) IMPROVING PEER REVIEW RESPONSIVENESS TO BENEFICIARY COMPLAINTS.--

(1) APPROPRIATE REVIEW OF COMPLAINTS REQUIRED.--Section 1154(a) of such Act (42 U.S.C. 1320c-3(a)), as amended by subsection (b)(2), is further amended by adding at the end the following new paragraph:

``(14) The organization shall conduct an appropriate review of all written complaints about the quality of services (for which payment may otherwise be made under title XVIII) not meeting professionally recognized standards of health care, if the complaint is filed with the organization by an individual entitled to benefits for such services under such title (or a person acting on the individual's behalf). The organization shall inform the individual (or representative) of the organization's conclusions respecting the complaint and final disposition of the complaint. Before the organization concludes that the quality of services does not meet professionally recognized standards of health care, the organization must provide the practitioner or person concerned with reasonable notice and opportunity for discussion.''.

(2) EFFECTIVE DATE.--The amendment made by paragraph (1) shall apply to complaints received on or after the first day of the first month that begins more than 9 months after the date of the enactment of this Act.

(f) SHARING OF INFORMATION BY PEER REVIEW ORGANIZATIONS.--

(1) IN GENERAL.--Section 1160(b)(1) of such Act (42 U.S.C. 1320c-9(b)(1)) is amended--

(A) by striking ``and'' at the end of subparagraph (B),

(B) by amending subparagraph (C) to read as follows:

``(C) to assist appropriate State agencies recognized by the Secretary as having responsibility for licensing or certification of providers or practitioners or to assist national accreditation bodies acting pursuant to section 1865 in accrediting providers for purposes of meeting the conditions described in title XVIII, which data and information shall be provided by the peer review organization to any such agency or body at the request of such agency or body relating to a specific case or to a possible pattern of substandard care, but only to the extent that such data and information are required by the agency or body in carry out its respective function which is within the jurisidiction of the agency or body under State law or under section 1865; and”; and

(C) by inserting after subpargraph (C) the following new subparagraph:

“(D) to assist State ombudsmen and State protection and advocacy officials who the Secretary identifies as having responsibility for assuring the quality of care furnished by providers or practitioners, which data and information shall be provided by the peer review organization to any such ombudsman or official upon request relating to a specific provider or practitioner, but only to the extent that such data and information are related to the quality of care furnished by a provider or practitioner and only if the peer review organization determines that the data and information may reflect a failure in a substantial number of cases or a gross and flagrant failure in one or more instances to provide services of a quality which meets professionally recognized standards of health care, and that the data and information are needed by the ombudsman or official in carrying out official duties;”.

(2) EFFECTIVE DATE.--The amendments made by paragraph (1) shall apply to requests for data and information made on and after the end of the 6-month period beginning on the date of the enactment of this Act.

(g) FUNDING OF ADDITIONAL PRO ACTIVITIES.--

(1) THROUGH AGREEMENTS WITH HOSPITALS, SKILLED NURSING FACILITIES, AND HOME HEALTH AGENCIES.--Section 1866(a) of such Act (42 U.S.C. 1395cc(a)) is amended--

(A) in paragraph (1)(F)--

(i) by redesignating clauses (i), (ii), and (iii), as subclauses (I), (II), and (III), respectively,

(ii) by inserting “(i)” after “(F)”, and

(iii) by adding at the end the following new clause:

“(ii) in the case of hospitals, skilled nursing facilities, and home health agencies, to maintain an agreement with a utilization and quality control peer review organization (which has a contract with the Secretary under part B of title XI for the area in which the hospital, facility, or agency is located), to perform the functions described in paragraph (4)(A);”; and

(B) by adding at the end the following new paragraph:

“(4)(A) Under the agreement required under paragraph (1)(F)(ii), the peer review organization must perform functions (other than those covered under an agreement under paragraph

(1)(F)(i)) under the third sentence of section 1154(a)(4)(A) and under section 1154(a)(14) with respect to services, furnished by the hospital, facility, or agency involved, for which payment may be made under this title.

``(B) For purposes of payment under this title, the cost of such an agreement to the hospital, facility, or agency shall be considered a cost incurred by such hospital, facility, or agency in providing covered services under this title and shall be paid directly by the Secretary to the peer review organization on behalf of such hospital, facility, or agency in accordance with a schedule established by the Secretary.

``(C) Such payments--

``(i) shall be transferred in appropriate proportions from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund, without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, and

``(ii) shall not be less in the aggregate for hospitals, facilities, and agencies for a fiscal year than the amounts the Secretary determines to be sufficient to cover the costs of such organizations' conducting the activities described in subparagraph (A) with respect to such hospitals, facilities, or agencies under part B of title XI.''.

(2) THROUGH AGREEMENTS WITH HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS.--Section 1876(i) of such Act (42 U.S.C. 1395mm(i)), as amended by section 10222(f) of this subtitle, is amended by adding at the end the following new paragraph:

``(7)(A) Each risk-sharing contract with an eligible organization under this section shall provide that the organization will maintain an agreement with a utilization and quality control peer review organization (which has a contract with the Secretary under part B of title XI for the area in which the eligible organization is located) under which the peer review organization will perform functions under section 1154(a)(4)(B) and section 1154(a)(14) (other than those performed under contracts described in section 1866(a)(1)(F)) with respect to services, furnished by the eligible organization, for which payment may be made under this title.

``(B) For purposes of payment under this title, the cost of such agreement to the eligible organization shall be considered a cost incurred by a provider of services in providing covered services under this title and shall be paid directly by the Secretary to the peer review organization on behalf of such eligible organization in accordance with a schedule established by the Secretary.

``(C) Such payments--

``(i) shall be transferred in appropriate proportions

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from the Federal Hospital Insurance Trust Fund and from the Supplementary Medical Insurance Trust Fund, without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, and

``(ii) shall not be less in the aggregate for such organizations for a fiscal year than the amounts the Secretary determines to be sufficient to cover the costs of such organizations' conducting activities described in subparagraph (A) with respect to such eligible organizations under part B of title XI.''.

(3) EFFECTIVE DATE.--

(A) HOSPITALS, SKILLED NURSING FACILITIES, AND HOME HEALTH AGENCIES.--The amendments made by paragraph (1) shall apply to provider agreements as of October 1, 1987.

(B) HMOS AND CMPS.--The amendment made by paragraph (2) shall apply to risk-sharing contracts with eligible organizations, under section 1876 of the Social Security Act, as of January 1, 1987.

PART 5--ASSURING ACCESS TO HEALTH CARE

SEC. 10251. INCENTIVES FOR THE ESTABLISHMENT OF STATE HEALTH INSURANCE POOLS.

(a) GENERAL RULE.--Chapter 41 of the Internal Revenue Code of 1954 is amended by adding at the end thereof the following new subchapter:

``Subchapter B--Large Employers Not Members of Qualified State Health Insurance Pools

``Sec. 4912. Tax on wages of large employers not members of qualified State health insurance pools.

``SEC. 4912. TAX ON WAGES OF LARGE EMPLOYERS NOT MEMBERS OF QUALIFIED STATE HEALTH INSURANCE POOLS.

``(a) TAX IMPOSED.--In the case of a large employer which--

``(1) employs any individual to perform services in a State that has established a qualified health insurance pool, and

``(2) is not a participating member of that pool in a taxable year at any time at which such services are performed,

there is hereby imposed a tax equal to 5 percent of the wages paid by the employer during the taxable year for services performed in the State by its employees.

``(b) LARGE EMPLOYER.--For purposes of this section--

``(1) IN GENERAL.--Except as provided in paragraph (2), the term ``large employer'' means an employer who, on each of some 20 days during the taxable year or the preceding taxable year, each day being in a different calendar week, employed for some portion of the day (whether or not at the same moment of time) 20 or more individuals.

``(2) EXCEPTION FOR GOVERNMENTAL UNITS.--The term `large employer' shall not include the United States, any State or political subdivision thereof, or any possession of the United States or any agency or instrumentality of any of the foregoing (including the United States Postal Service and Postal Rate Commission); except that such term shall include any nonappropriated fund instrumentality of the United States.

``(c) QUALIFIED HEALTH INSURANCE POOL.--For purposes of this section, the term `qualified health insurance pool' means any organization which--

``(1) is a nonprofit corporation established pursuant to and regulated by State law;

``(2) permits any large employer doing business in the State to be a participating members;

``(3) makes available (without regard to health conditions) to all residents of the State, who are not eligible for benefits under part A of title XVIII of the Social Security Act, levels of health insurance typical of the levels of coverage provided through large employer groups, except that--

``(A) any such level of insurance must limit the amount of the annual out-of-pocket expenses for covered services under individual coverage to $1,500 and under family coverage to $3,000,

``(B) any such level of insurance may not establish a lifetime benefit limit for any individual of less than $500,000,

``(C) subject to subparagraph (A), such insurance may provide for a choice of deductibles (in addition to the deductibles typical of levels of coverage provided through large employer groups), but not to exceed $1,000 for each covered individual,

``(D) such insurance may deny coverage for covered services for preexisting conditions for a period not to exceed 6 months, and

``(E) such insurance must include as covered services the purchase and repair of medically necessary durable medical equipment;

``(4) charges a pool premium rate expected to be self-supporting based upon a reasonable actuarial determination of anticipated experience and expected expenses, such pool premium rate in no event to exceed 150 percent of average premium rates for individual standard risks in the State for comparable coverage; and

``(5) assesses losses of the pool equitably among all participating members.

Nothing in this subsection shall be construed as preventing a State or other entity from providing for payment of part or all of the premium of an enrollee and from varying the amount of such payment based on the enrollee's income or other basis.

``(d) OTHER DEFINITIONS.--

``(1) USE OF FUTA DEFINITIONS.--For purposes of this section, the terms `wages', `employee', and `employer' have the meanings given such terms in subsections (a), (c), and (d), respectively, of section 3401.

``(2) STATE.--The term `State' includes the District of Columbia and the Commonwealth of Puerto Rico.

``(e) CROSS REFERENCE.--

(1) For provision denying deduction for tax imposed by this section, see section 275(a)(6).

(2) For provisions making deficiency procedures applicable to tax imposed by this section, see section 6211 et seq.

(b) CLERICAL AMENDMENTS.--

(1) Chapter 41 of such Code is amended by striking the chapter heading and inserting the following:

``**CHAPTER 41--PUBLIC CHARITIES; LARGE EMPLOYERS NOT MEMBERS OF QUALIFIED STATE HEALTH INSURANCE POOLS**

``Subchapter A. Public charities.
``Subchapter B. Large employers not members of qualified State health insurance pools.

``**Subchapter A--Public Charities**''.

(2) The table of chapters for subtitle D of such Code is amended by striking the item relating to chapter 41 and inserting the following:

``Chapter 41. Public charities; large employers not members of qualified State health insurance pools.''

(3) Subparagraph (B) of section 6104(c)(1) of such Code is amended by striking `or chapter 41 or 42'' and inserting ``, subchapter A of chapter 41 or chapter 42''.

(c) EFFECTIVE DATE.--The amendments made by this section shall apply to taxable years beginning on or after January 1, 1988.

(d) ESTABLISHMENT OF QUALIFIED STATE HEALTH INSURANCE POOLS.--Congress intends that each State should establish a qualified health insurance pool (described in section 4912(c) of the Internal Revenue Code of 1954) by not later than January 1, 1988, or, if later, the end of the first regular State legislative session that begins after the date of the enactment of this Act.

SEC. 10252. COBRA TECHNICAL AMENDMENTS RELATING TO CONTINUATION OF EMPLOYER-BASED HEALTH INSURANCE COVERAGE.

(a) MODIFICATION OF COVERAGE.--Paragraph (2)(A) of section 162(k) of the Internal Revenue Code of 1954 (relating to type of benefit coverage) is amended by adding at the end the following: ``If coverage is modified under the plan for similarly situated beneficiaries, such coverage shall also be modified in the same manner for all qualified beneficiaries covered under the plan.''.

(b) MAXIMUM PERIOD OF CONTINUATION COVERAGE.--Paragraph (2)(B)(i) of such section (relating to maximum period of continuation coverage) is amended--

(1) by striking out the period at the end and inserting a semicolon, and

(2) by adding at the end the following:

except that in the case of a qualified beneficiary with respect to whom more than one qualifying event occurs, the date may be extended under this clause but in no case may the coverage period with respect to such events (other than the period applicable to a qualifying event described in paragraph (3)(F)) exceed a 36-month period for such qualified beneficiary.''.

(c) GRACE PERIOD FOR PAYMENT OF PREMIUMS.--Paragraph (2)(B)(iii) of such section (relating to failure to pay premium) is amended by adding at the end the following: ``Payment shall be considered to be timely if made within 30 days of the date due or within such longer period as applies to or under the plan.''

(d) ELECTION BY BENEFICIARIES.--Paragraph (5) of such section (relating to elections) is amended by adding at the end the following new subparagraph:

``(C) RIGHT TO INDIVIDUAL ELECTION.--Notwithstanding subparagraph (B), each qualified beneficiary is entitled to make a separate election with respect to continuation coverage for that beneficiary and, if there is a choice of type of coverage under the plan, to make a separate selection among such types of coverage.''.

(e) NOTICE REQUIREMENT.--Paragraph (6)(C) of such section (relating to notice requirements) is amended by inserting ``within 60 days of the date of the qualifying event'' after ``paragraph (3)''.

(f) EFFECTIVE DATE.--The amendments made by this section shall be effective as if they had been included in the enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985.

SEC. 10253. CONTINUATION COVERAGE FOR RETIREES IN CASES OF BANKRUPTCIES.

(a) LOSS OF COVERAGE OF RETIREE THROUGH BANKRUPTCY AS QUALIFYING EVENT.--Paragraph (3) of section 162(k) of the Internal Revenue Code of 1954 (relating to qualifying event with respect to continuation coverage requirements under group health plans) is amended by adding at the end the following:

``(F) A proceeding in a case under title 11, United States Code, commencing on or after July 1, 1986, with respect to the employer from whose employment the covered employee retired at any time.

In the case of an event described in subparagraph (F), a loss of coverage includes a substantial elimination of coverage with respect to a qualified beneficiary described in paragraph (7)(B)(iii) within one year before or after the date of commencement of the proceeding.''.

(b) PERIOD OF CONTINUATION COVERAGE.--

(1) LIFE OF COVERED EMPLOYEE OR WIDOW AND ADDITIONAL 36 MONTHS FOR SURVIVING SPOUSE AND DEPENDENTS.--Clause (i) of section 162(k)(2)(B) of such Code (relating to maximum period) is amended--

(A) by striking ``and'' at the end of subclause (I),

(B) in subclause (II), by inserting ``or (II)'' after ``(I)'',

(C) by redesignating subclause (II) as subclause (III), and

(D) by inserting after subclause (I) the following new subclause:

``(II) a qualifying event described in paragraph (3)(F) (relating to bankruptcy proceedings), the date of the death of the covered employee or qualified beneficiary (described in paragraph (7)(B)(iii)(III)), or in the case of the surviving spouse or dependent children of the covered employee, 36 months after the date of the death of the covered employee, and''.

(2) COVERAGE NOT LOST UPON ENTITLEMENT TO MEDICARE BENEFITS.--Subclause (II) of section 162(k)(2)(B)(iv) of such Code (relating to reemployment or medicare eligibility) is amended by inserting ``in the case of a qualified beneficiary other than a qualified beneficiary described in paragraph (7)(B)(iii),'' before ``entitled''.

(c) DEFINITION OF QUALIFIED BENEFICIARY MODIFIED IN REORGANIZATION CASES.--Section 162(k)(7)(B) of such Code (relating to special rule for termination and reduced employment in definition of qualified beneficiary) is amended by adding at the end the following new clause:

``(iii) SPECIAL RULE FOR RETIREES AND WIDOWS.--In the case of a qualifying event described in paragraph (3)(F), the term `qualified beneficiary' includes a covered employee who had retired on or before the date of substantial elimination of coverage and any other individual who, on the day before such qualifying event, is a beneficiary under the plan--

``(I) as the spouse of the covered employee,

``(II) as the dependent child of the employee, or

``(III) as the surviving spouse of the covered employee.''.

(d) EFFECTIVE DATE.--

(1) IN GENERAL.--The amendments made by this section shall take effect as if included in section 10001 of the Consolidated Omnibus Budget Reconciliation Act of 1985.

(2) TREATMENT OF CERTAIN BANKRUPTCY PROCEEDINGS.--Notwithstanding paragraph (1) and section 10001(e) of the Consolidated Omnibus Budget Reconciliation Act of 1985, the amendments made by this section and by section 10001 of such Act shall apply in the case of plan years ending during the 12-month period beginning July 1, 1986, but only with respect to--

(A) a qualifying event described in section 162(k)(3)(F) of the Internal Revenue Code of 1954, and

(B) a qualifying event described in section 162(k)(3)(A) of such Code relating to the death of a retired employee occurring after the date of the qualifying event described in subparagraph (A).

(3) TREATMENT OF CURRENT RETIREES.--Section 162(k)(3)(F) of the Internal Revenue Code of 1954 applies to covered employees who retired before, on, or after the date of the enactment of this Act.

Subtitle D--Revenue Provisions

SEC. 10301. EXTENSION OF EXCISE TAX ON COMMUNICATIONS SERVICES.

(a) IN GENERAL.--The table contained in paragraph (2) of section 4251(b) of the Internal Revenue Code of 1954 (relating to imposition of tax on communications services) is amended to read as follows:

``With respect to amounts paid pursuant to bills first rendered:	The applicable percentage is:
During 1987, 1988, or 1989	3
During 1990 or thereafter	0.''

(b) EFFECTIVE DATE.--The amendment made by subsection (a) shall apply with respect to amounts paid for communications services pursuant to bills first rendered after December 31, 1986.

SEC. 10302. STUDY OF COMMUNICATION SERVICES NOT SUBJECT TO FEDERAL EXCISE TAX.

(a) IN GENERAL.--The Secretary of the Treasury or his delegate shall conduct a study of communication services which are exempt from the tax imposed by section 4251 of the Internal Revenue Code of 1954 by reason of being a private communication service (as defined in section 4252(d) of such Code) or by reason of a specific exemption from such tax under section 4253 of such Code. Such study shall include an estimate of the reduction in tax revenues by reason of each such exemption and shall describe the types of persons which benefit from each such exemption.

(b) REPORT.--The report of the study under subsection (a) shall be submitted, not later than December 31, 1987, to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate.

V. Additional Views

ADDITIONAL REMARKS OF MR. FRENZEL

The Ways and Means Committee's reconciliation action fell $2 billion short of its reconciliation target for FY 1987. It ought to be rejected by the Budget Committee, the Rules Committee, and the House.

Despite its inadequacies, the Ways and Means reconciliation won't be rejected. Instead, victory will be declared because the 3 year reconciliation savings do achieve the $11.6 billion target.

In my judgment, the first year, FY 1987, is the only one that counts. If we can't meet our Gramm-Rudman-Hollings objective in 1987, we surely aren't going to meet it in 1988 or 1989.

The Committee has fallen short, therefore, of its most important obligation. That isn't good news, but it isn't as bad as what follows.

The bad news is the way in which the Committee achieved its 3 year target. About half of it is in new taxes.

The new taxes are an extension of telephone taxes totaling $3.6 billion, and an extension of FUTA taxes of $2.2 billion. The telephone tax, of course, falls most heavily on individual consumers.

The FUTA tax, a 2/10 of 1% levy of payroll to pay the debt of an overambitious unemployment compensation program of the mid-1970s, is a burden that discourages employers from hiring new employees. A payroll tax is, inevitably, a tax on jobs. This one should be allowed to expire in mid-1987 when the debt is paid off.

Not meeting the target is once; inflicting new taxes is twice; but the Committee really struck out when it included new programs in its reconciliation bill. One such adventure made mandatory a now discretionary state AFDC program costing nearly $400 million.

When a responsible committee like Ways and Means adds new programs, other more profligate committees seize on that action to add new programs of their own.

Overall, the Committee's reconciliation bill is inadequate, unfair, and mischievous. It should be rejected. The Committee should be directed to make real spending reductions without new taxes or new programs.

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